

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1



14285

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14284

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital			d. STREET ADDRESS Rt. 1, Box 2840		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Tyrone Middle Elmer Last Addison			4. DATE OF DEATH Month October Day 2 Year 19 66		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7/8/66		9. AGE (In years last birthday) yrs. 2 25 IF UNDER 1 YEAR: Months 2 Days 25 IF UNDER 24 HRS: Hours 25 Min 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Olney, Maryland	
13. FATHER'S NAME Unknown			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			14. MOTHER'S MAIDEN NAME Estelle L. Addison		
16. SOCIAL SECURITY NO. none			17. INFORMANT Montgomery Address Gen'l. Hospital records Olney, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory failure, DUE TO 773.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) etiology undetermined DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) Belden Reap, M. D.		22. DATE SIGNED OCT. 3, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-66		23c. NAME OF CEMETERY OR CREMATORY Ash Memorial.,	
23d. LOCATION (City or Town) Sandy Spring, Md.		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR Rufus L. Suowder		ADDRESS Rockville, Md.		25a. REC'D BY REGISTRAR DATE OCT 6 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge					

14541

26541

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14286

CERTIFICATE OF DEATH

14285

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Virginia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 522 South Courthouse Road	
3. NAME OF DECEASED (Type or print) First Middle Last Murray Craven ALEXANDER		4. DATE OF DEATH Month Day Year October 30 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 30 July 1912
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Navy (Retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Charlotte, North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Murray C. Alexander Sr		14. MOTHER'S MAIDEN NAME Margaret L. Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 238-03-0339	
17. INFORMANT (Wife) Mrs. Doris B. Alexander Rd., Arlington, Va.		18. 522 S. Court House	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 30 October 1966 , to 30 October 1966 , that (1) (we) last saw the deceased alive on 30 October 1966 , and that death occurred at 11:30 PM , from causes and on the date stated above.			
22a. SIGNATURE Raymond B. Johnson		22b. DATE SIGNED 31 October 1966	
22c. PHYSICIAN'S NAME (Type) Raymond B. Johnson LT MC USN		22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2 Nov 66	23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery	23d. LOCATION (City or Town) (County) (State) Arlington Virginia
24. FUNERAL DIRECTOR W. G. Graft Arlington Funeral Home		25a. REC'D BY REGISTRAR NOV 2 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

14288

14288

Montgomery

Virginia

Bethesda (Mental)

Arlington

Naval Hospital

522 South Commerce Road

Henry Caven ALBANY

October

Raymond E. Johnson JR MD USN

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14287

CERTIFICATE OF DEATH

14286

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>6 Jefferson Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Carl Anderson</u>		4. DATE OF DEATH <u>Oct 17 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-25-68</u>
9. AGE (In years last birthday) <u>98</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Road Constructor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Carolina Thorgrimson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>572 32 8548</u>	
17. INFORMANT <u>Washington Sanitarium & Hospital Records</u>		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>493X Ventricular Fibrillation</u> DUE TO (b) <u>Pneumonia</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Pneumonia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>10-1</u> , 19 <u>66</u> , to <u>10-17</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>10-16</u> , 19 <u>66</u> , and that death occurred at <u>9 AM</u> , from causes and on the date stated above.		
22a. SIGNATURE <u>R. H. Sandstrom</u>	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-17-66</u>
22c. PHYSICIAN'S NAME (Type) <u>R. H. SANDSTROM</u>	22d. ADDRESS <u>7701 Carroll Ave TRK, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 20, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dorset Lawn Cemetery</u>
23d. LOCATION (City or Town) (County) (State) <u>Los Angeles California</u>		
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>
ADDRESS <u>254 Carroll St NW Wash DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>OCT 18 1966</u>		

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MEDICAL CERTIFICATION

Items 18&21 Film 383 12-19 MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14288		MEDICAL EXAMINER'S CERTIFICATE OF DEATH						14287			
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville, 1511					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital						d. STREET ADDRESS 13517 Sloan St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Richard Carl Annis						4. DATE OF DEATH Month October Day 7 Year 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/8/66		9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 29 Days 29 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant				10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Bethesda, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James L. Annis						14. MOTHER'S MAIDEN NAME Elizabeth Pound					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO None				16. SOCIAL SECURITY NO. None		17. INFORMANT Father, Address James Annis 13517 Sloan St. Rockville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 492-X IMMEDIATE CAUSE (a) Acute interstitial pneumonitis DUE TO (b) of probable viral origin Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Reap M.D. EXAMINER'S NAME (Type) Belden R. Reap						22. DATE SIGNED Oct. 7, 1966 CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 11502 Grandview Ave. Wheaton, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Oct. 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Florida Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Florida			
24. FUNERAL DIRECTOR Glenn Carter Warner E. Pumphrey, Inc.				ADDRESS 8434 Georgia Ave. Silver Spring, Md.		25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

1954

1954

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
14289					14288					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>23 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Md.</u>					d. STREET ADDRESS <u>112 Forest Drive</u>					
3. NAME OF DECEASED (Type or print) <u>Lester John Auker</u>			First Middle Last		4. DATE OF DEATH <u>October 5 1966</u>		Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9 February 1901</u>		9. AGE (In years last birthday) <u>65 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Automobile Tires</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Harry W. Auker</u>					14. MOTHER'S MAIDEN NAME <u>Nora Woodward</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>1918-1920</u>		17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda, Maryland 20014</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory & Cardiac arrest</u> DUE TO (b) <u>Cardiovascular accident</u> DUE TO (c) <u>Chronic Myelogenous Leukemia</u> INTERVAL BETWEEN ONSET AND DEATH <u>6 Days</u> <u>18 Months</u>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that the (this hospital) attended the deceased from <u>September 12, 1966</u> , to <u>October 5, 1966</u> , that the (we) last saw the deceased alive on <u>October 5, 1966</u> , and that death occurred at <u>4:40 PM</u> , from the causes and on the date stated above.										
22a. SIGNATURE <u>Herbert E. Kann, Jr., MD.</u>					22b. DATE SIGNED <u>5 October 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Herbert E. Kann, Jr., MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>					23b. DATE THEREOF <u>Oct 7, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>(Ashes) Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John J. Hafet</u>					25a. REC'D BY REGISTRAR <u>John J. Hafet</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Hafet</u>			

1937

DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14290

CERTIFICATE OF DEATH

14289

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8502 16th St.		d. STREET ADDRESS 8502 16th St.	
3. NAME OF DECEASED (Type or print) First JOSE Middle EULOGIO Last AYALA		4. DATE OF DEATH Month 10 Day 5 Year 1966	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-7-77
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 15 Days 1	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired railroad engineer		12. CITIZEN OF WHAT COUNTRY? MEXICO	
13. FATHER'S NAME DIONISIO AYALA		14. MOTHER'S MAIDEN NAME THOMASA PEREZ	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT GUADALUPE A. SOUTER (Daughter)		Address 8502-16th St Silver Sp, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer, urinary bladder			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 Oct , 1966, that (I) (we) last saw the deceased alive on 10-3-1966 , and that death occurred at 2A M, from causes and on the date stated above.			
22a. SIGNATURE Irwin H. Ardham		22b. DATE SIGNED 10-5-66	
22c. PHYSICIAN'S NAME (Type) IRWIN H. ARDAM, M.D.		22d. ADDRESS 1712 - I - St., N.W. WASH., D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 10-6-66	23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	23d. LOCATION (City or Town) (County) (State) Silver Spring, Md.
24. FUNERAL DIRECTOR Joseph Gawlers Sons		25a. REC'D BY REGISTRAR Wash DC	
25b. REGISTRAR'S SIGNATURE 5130 Wisc Ave NW		DATE OCT 7 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14291

CERTIFICATE OF DEATH

14290

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		d. STREET ADDRESS <u>3023 - 14 Street N. W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>Mayer</u> Last <u>Baer</u>		4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-17-1887</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>10</u> Hours <u>4</u> Min. <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt. Clerk- Interior Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interior Dept.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alfred D. Baer</u>		14. MOTHER'S MAIDEN NAME <u>Annie E. Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes WWI</u>		16. SOCIAL SECURITY NO. <u>578-50-8172</u>	
17. INFORMANT <u>Miss Elizabeth C. Baer</u>		Address <u>1348 Prichard St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>4 YRS.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Chronic Congestive Ht. Failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/26</u> , 19 <u>66</u> , to <u>10/4</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>66</u> , and that death occurred at <u>12:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u>		22b. DATE SIGNED <u>10/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond T. Benack MD</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>10/5/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chartiers Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Carnegie, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>S.H. Hines Co. 2901-14 St. N.W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 7 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1953

CERTIFICATE OF DEATH

1953

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U.S. GOVERNMENT PRINTING OFFICE: 1953

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14292

14291

1. PLACE OF DEATH o. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sakoma Park</i>				c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> <i>47-3</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7300 Baltimore Ave</i>				d. STREET ADDRESS <i>7538 Eastern Ave. N.W.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Margaret Suzanne Bailey</i>				4. DATE OF DEATH <i>Oct 4 1966</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 2, 1873</i>		9. AGE (In years last birthday) <i>92</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at Home</i>		11. BIRTHPLACE (State or foreign country) <i>Charles Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alexander Edelen</i>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mary B. Veirbruchen (same as #2.)</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i> <i>4330</i> DUE TO <i>Chronic Myocarditis</i> <i>Undetermined</i>							
(b) <i>Generalized Arterio-sclerosis</i> <i>Undetermined</i>							
(c) <i>Cerebro-sclerosis</i> <i>Undetermined</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Fracture left hip Oct 3, 1965</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell in home</i>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>Oct 3 1966</i> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Washington</i> (County) <i>D.C.</i> (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Oct 1 1966</i> to <i>Oct 4 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct 4 1966</i> , and that death occurred at <i>413</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>George L Ball</i>				22b. DATE SIGNED <i>Oct 4, 1966</i>		22c. PHYSICIAN'S NAME (Type) <i>George L Ball</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 8, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (City, town, or county) <i>Suitland, Md. Co. Md.</i> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John Walters</i> ADDRESS <i>254 Carroll NW. W.C.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE	
				DATE <i>OCT 10 1966</i>			

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MEDICAL CERTIFICATION

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1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14293

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14292

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>Home</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Tulip Lane</u>		d. STREET ADDRESS <u>Tulip Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Howard A Bandy</u>		4. DATE OF DEATH Month <u>October</u> Day <u>20</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/19/08</u>
9. AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>head of Estimating Dept-Printing Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printing</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Emanuel Bandy</u>		14. MOTHER'S MAIDEN NAME <u>Lola Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-22-7079</u>	
17. INFORMANT <u>May H. Bandy - wife</u>		Address <u>Same as above</u> Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis -</u> DUE TO (b) <u>Cardiovascular Disease.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>years</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-22-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Montgomery County, Md.</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		22. DATE SIGNED <u>10/20/66</u>	

11505

1450

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14294 CERTIFICATE OF DEATH 14293

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u> c. LENGTH OF STAY IN 1b <u>1 month</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cedar Haven Rest Home.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8214 Cedar Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Jay BARKER</u> First Middle Last 4. DATE OF DEATH <u>Oct. 10 1966</u> Month Day Year		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>4/16/1887</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired clerk</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>New York State</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Barker</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>34-36-393A</u> 17. INFORMANT <u>Joann B. Comstock</u> Address <u>12406 Downer Dr. Wheaton, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Conjunctive Heart Failure Pulmonary Edema</u> <u>4221</u> DUE TO (b) <u>Accro.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Old Age</u> Pneumonia Urinary Infection INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Carcinomatosis from Prostate</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>None</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 26</u> , 19 <u>66</u> , to <u>Oct 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 9</u> 19 <u>66</u> , and that death occurred at <u>1:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell C. Bufalino</u> 22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino, M.D.</u>		22b. DATE SIGNED <u>Oct 10, 1966</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>1429 Univ. Blvd. W. S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Oct. 13, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>		24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u> <u>Warner E. Humphrey, Inc.</u> 25a. REC'D BY REGISTRAR <u>OCT 14 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14295

CERTIFICATE OF DEATH

14294

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>716 Gist ave.</u>	
3. NAME OF DECEASED (Type or print) <u>EUGENE</u> First <u>(NMD)</u> Middle <u>BARNES</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard (Retired)</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>Asso. Perpetual Bldg.</u>	9c. AGE (In years last birthday) <u>70</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Asso. Perpetual Bldg.</u>	10c. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry C. Barnes</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Marlow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>218-20-1466</u>	
17. INFORMANT <u>Margaret Barnes, wife</u>		18. ADDRESS <u>716 Gist Avenue, S.S., Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema of lungs</u> 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decomposition</u> DUE TO (c) <u>.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>8-10 days</u> <u>4-5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Atherosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1946</u> , to <u>1966</u> , that (I) (we) lost the deceased alive on <u>30 Sept 1966</u> , and that death occurred at <u>7:14 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>William D. And</u>		22b. DATE SIGNED <u>10/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>		22d. ADDRESS <u>9006 Colesville Rd., S.S., Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 4, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>		25a. REC'D BY REGISTRAR <u>OCT 5 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Silver Spring, Md.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

4. 7. 2005

2024

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14296

CERTIFICATE OF DEATH

14295

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA, MARYLAND c. LENGTH OF STAY IN 1b 3 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RESMOR SANITARIUM				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA d. STREET ADDRESS 5534 Johnson Avenue e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last William Daniel Barnett				4. DATE OF DEATH Month Day Year Oct. 14 19 66											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 1881		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist				10b. KIND OF BUSINESS OR INDUSTRY Pharmacist				11. BIRTHPLACE (County & State, or foreign country) Texas				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John C. Barnett						14. MOTHER'S MAIDEN NAME Arcadia Hall									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT Edith Barnett. 5534 Johnson Ave Bethesda, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease 57 yrs DUE TO (c) Arteriosclerotic Heart Disease 10+ yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 60 yrs. Hypertension, CVA 10+ yrs												INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 10/11/66 , 19 66 , to present , 19 66 , that (I) (we) last saw the deceased alive on 10/11/66 , and that death occurred at 11:00 M, from causes and on the date stated above.															
22a. SIGNATURE Charles Savarese M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 10/14/66									
22c. PHYSICIAN'S NAME (Type) Charles Savarese, M.D.						22d. ADDRESS Rockville, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 10-17-66		23c. NAME OF CEMETERY OR CREMATORY Park Lawn				23d. LOCATION (City or Town) (County) (State) Rockville. Montg, Md.					
24. FUNERAL DIRECTOR Ernest C. Gartner						ADDRESS 1010 1st St. N.E. Washington, D.C.				25a. REC'D BY REGISTRAR DATE OCT 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

425

RESPIRATORY

1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

4416

Lyons

32

3462

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14297

Items 1b, 1d, 11m, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

14296

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rockville Md.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Grosvenor Park Apts. 10500 Rockville Pike, Apt. 1311</i>		d. STREET ADDRESS <i>10500 Rockville Pike</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>ROBERT</i> Middle <i>J.</i> Last <i>BARRETT</i>		4. DATE OF DEATH Month <i>10</i> Day <i>29</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 20th 1902</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Det Maj Dc. Police Dept</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Washington</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William J. Barrett</i>		14. MOTHER'S MAIDEN NAME <i>Susan C. Dell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mildred Barrett</i> Address <i>10500 Rockville Pike</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <i>Encephelomalacia</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>3 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Hypertensive cardiovascular disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9 Oct 1966</i> to <i>29 Oct 1966</i> that (I) (we) last saw the deceased alive on <i>28 Oct 1966</i> and that death occurred at <i>11:26 AM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Erich D. Kyll M.D.</i> M.D.		22b. DATE SIGNED <i>29 Oct 66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>4602 Rosedale Bethesda Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>11-3-66</i>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <i>State of Sequen</i>		23d. LOCATION (City, town, or county) (State) <i>Rockville Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas B. Hurdan</i> ADDRESS <i>4748 Wisconsin Ave NW</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 3 1966</i>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

104

14500

CENTRAL OF GEORGIA

14521

NOV 1958

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14298

CERTIFICATE OF DEATH

14297

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY St Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 9das	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U. S. Naval Hospital		d. STREET ADDRESS Brento Apartments	
3. NAME OF DECEASED (Type or print) First Middle Last Virginia May Barsosky		4. DATE OF DEATH Month Day Year October 5 19 66	
5. SEX Female	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7 February 1944
9. AGE (In years last birthday) 22 yrs.		IF UNDER 1 YEAR Months Days 22	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Tokos		14. MOTHER'S MAIDEN NAME Mary Kinny	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT John Barsosky		Address Brento Apts Leonardtown Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Shock DUE TO (b) Open Heart Surgery DUE TO (c) Congenital Heart Disease - Pulmonary Stenosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (he) (this hospital) attended the deceased from 26 Sept , 19 66 , to 5 Oct , 19 66 , that (he) (we) last saw the deceased alive on 5 Oct , 19 66 , and that death occurred at 9:10 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>D. H. Gaylor</i>		22b. DATE SIGNED 6 Oct 1966	
22c. PHYSICIAN'S NAME (Type) D. H. GAYLOR, CDR, MC, USN		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct 10, 1966	23c. NAME OF CEMETERY OR CREMATORY St. Michaels	23d. LOCATION (City or Town) (County) (State) Binghampton NY
24. FUNERAL DIRECTOR Joseph Gawler, 5130 Wisconsin Ave, Wash. D.C.		25a. REC'D BY REGISTRAR OCT 10 1966	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1951

CERTIFICATE OF DEATH

1951

Blank form with horizontal lines for text entry.

Vertical text on the right margin, including a date stamp: 1951 OCT 10 10 10 AM.

1 (M)
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14299 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 14298

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Giney</u> c. LENGTH OF STAY IN 1b <u>72 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Mont. Gen. Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Unity Rt. #1 Brookville</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FANNIE C. BEALL</u> First Middle Last 4. DATE OF DEATH <u>Oct. 15 1966</u> Month Day Year		5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 12, 1877</u> 9. AGE (In years last birthday) <u>88</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. wife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Illinois</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jeremiah Cantrall</u> 14. MOTHER'S MAIDEN NAME <u>Henriella Downs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Edna Charlton</u> Address <u>Same as 2</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia -</u> 9040 Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) <u>Fracture of hip -</u> DUE TO (c) <u>Generalized Arterio Sclerosis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell at home causing Fracture of Hip.</u> 20c. TIME OF INJURY Month, Day, Year <u>8-3 1966</u> Hour a.m. <u>2:00</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Unity</u> (County) <u>Mont.</u> (State) <u>Md.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>John G. Ball</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>10/15/66</u> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10-18-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel</u> 23d. LOCATION (City, town or county) <u>Sunshine</u> (State) <u>Mont., Md.</u>		24. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonville, Md.</u> 25a. REC'D BY REGISTRAR <u>OCT 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

11506

14332

John O. Bell

Shanghai, China

Francis H. Barber
10-1-55
Mr. Carmel
Lawsonville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
14300				CERTIFICATE OF DEATH				14299							
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>15-1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>							2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> d. STREET ADDRESS <u>1218 Highwood Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) <u>Timothy ALAN Beall</u>			4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1966</u>		5. SEX <u>m.</u>			6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-14-66</u>		9. AGE (In years last birthday) yrs. <u>12</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>2</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Tech.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRONICS</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>John P. Beall</u>				14. MOTHER'S MAIDEN NAME <u>BARBARA A. Lumsden</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>--</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT Address <u>Mother AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTERPULMONARY Hemorrhage</u> 7710 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7710</u> DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH <u>23 1/2 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>14 OCT</u> , 19 <u>66</u> , to <u>15 OCT</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>15 OCT</u> , 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.															
22a. SIGNATURE <u>Gary Brecken</u>								M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>15 OCT. 66</u>					
22c. PHYSICIAN'S NAME (Type) <u>Gary Brecken</u>								22d. ADDRESS <u>Silver Spring, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>				23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u>					
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home-1331 Rockville Pike Rockville, Md.</u>								25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>OCT 18 1966</u>															

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14301 **CERTIFICATE OF DEATH** **14300**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Potomac Valley Nursing Home		d. STREET ADDRESS 814 Viers Mill Road	
3. NAME OF DECEASED (Type or print) First LUCY Middle M. Last BELT		4. DATE OF DEATH Month Oct. Day 13 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1887
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward L. Heim		14. MOTHER'S MAIDEN NAME Malinda Kemp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-5099B	
17. INFORMANT Wm. Stacy Belt		Address 814 Viers Mill Road Rockville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolus 332X DUE TO (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10 yrs	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Aug , 19 66 to 13 Oct , 19 66 , that (we) last saw the deceased alive on 12 Oct , 19 66 , and that death occurred at 2:15 M, from the causes and on the date stated above.			
22a. SIGNATURE W. S. Murphy		22b. DATE SIGNED 10/13/66	
22c. PHYSICIAN'S NAME (Type) W. S. Murphy for Wm. G. Hall		22d. ADDRESS Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 15, 1966	23c. NAME OF CEMETERY OR CREMATORY Forest Oak Cemetery	23d. LOCATION (City, town or county) (State) Gaithersburg, Maryland
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 18 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Rockville

Rockville

814 Viere Mill Road

814 Viere Mill Road

Oct. 13, 1968

RECEIVED

M.

IVORY

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May 9, 1967

Female White

U.S.A.

Maryland

Howardsville

Melinda Kemp

Howard L. Kemp

814 Viere Mill Road
Rockville, Maryland

578-10-5008 M. Kelly Bell
Rockville, Maryland

no

Delmar, Maryland

Forest Oak Cemetery

Burial

131 Rockville Pike

Tyson Wheeler

Rockville, Maryland

FOR STATE
HEALTH DEPT.

14302

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14301

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>	
c. LENGTH OF STAY IN 1b <i>DOA</i>		d. STREET ADDRESS <i>1810 Belvedere Blvd.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Wash San & Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Harold Milton Bennett</i>		4. DATE OF DEATH Month Day Year <i>10 19 1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 6-19</i>
9. AGE (In years last birthday) yrs. <i>47</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>waiter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Restaurant</i>	
11. BIRTHPLACE (State or foreign country) <i>Clarksburg Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>	
13. FATHER'S NAME <i>Joseph A. Bennett</i>		14. MOTHER'S MAIDEN NAME <i>Minnie Becraft</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>410 11</i>	
17. INFORMANT <i>Joan U. Adkins</i>		Address <i>4309 Ivy Glenn Road Wheaton, Maryland</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>5811</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>severe</i> DUE TO (c) <i>Alcoholism</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Balden R. Reap</i> EXAMINER'S NAME (Type) <i>Balden R. Reap</i>		22. DATE SIGNED <i>Oct. 20, 1966</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 24, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Arlington National Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Arlington, Virginia</i>	
24. FUNERAL DIRECTOR <i>C. Glen Carter</i> <i>Warner E. Pumphrey, Inc.</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 25 1966</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in parenthesis in parenthesis Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14303

CERTIFICATE OF DEATH

14302

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Virginia</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>1710 C Commonwealth Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Brund Giordano Benvenuti</u>		4. DATE OF DEATH Month Day Year <u>Oct 4 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-16-09</u>
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk - Woodward + Lothrop</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Italy</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Dominic Benvenuti</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Salatero</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-48-0945</u>	
17. INFORMANT <u>Janina Benvenuti</u>		1710 C. Address <u>Alex. Va.</u>	

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Branchiopneumonia</u> 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Obstruction, Bacterial infection</u> DUE TO (c) <u>Bronchogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9/3</u> , 19 <u>66</u> , to <u>10/4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> 19 <u>66</u> , and that death occurred at <u>11:59</u> M, from causes and on the date stated above.		
22a. SIGNATURE <u>Leeannth Crize</u> M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-7-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Alexandria, Va</u>
24. FUNERAL DIRECTOR <u>Everly-Wheatley Funeral Home - Alex. Va.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

2024

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA @ 10:57 AM</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>9514 Charred Oak Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALAN Stephen BERKMAN</u>		4. DATE OF DEATH Month Day Year <u>Oct 7 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6-15-34</u> 9. AGE (In years last birthday) <u>32</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Physicist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. Research</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>MURRY BERKMAN</u>		14. MOTHER'S MAIDEN NAME <u>Mariam Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT <u>Father</u> Address <u>Same as Item 2.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Injuries, multiple (attributed to automobile)</u> 8124 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran down bank onto highway into path of Auto.</u>		
20c. TIME OF INJURY Month, Day, Year <u>10:30 p.m. 10 7 1966</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	20f. (City or town) (County) (State) <u>Bethesda Mont. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John M. Ball</u> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> - <u>10/8/66</u> 22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/9/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wellwood Cem.</u> 23d. LOCATION (City or Town) (County) (State) <u>Pinelawn, New York</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey, Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

11303

11303

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14305

CERTIFICATE OF DEATH

14304

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>3 DAS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
3. NAME OF DECEASED (Type or print) <u>MICHAEL F BIANCHINI</u>		d. STREET ADDRESS <u>8001 EASTERN AVE</u>	
5. SEX <u>Male</u>		6. COLD R DR RACE <u>W</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN 7, 1898</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church Maintenance</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BIG LOTS TALL Y</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bianchini</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>186-26-6428</u>	
17. INFORMANT <u>Mrs. Anna Catino</u>		18. ADDRESS <u>8001 Eastern Ave. Silver Spring, Md.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracerebral hemorrhage, right parietal</u> DUE TO (b) <u>lobe</u> DUE TO (c) <u>Hypertensive cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>64</u> to <u>10-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>OCT 23</u> , 19 <u>66</u> , and that death occurred at <u>8:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Kramer</u>		22b. DATE SIGNED <u>10-23-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT KRAMER</u>		22d. ADDRESS <u>8484 16th ST. SS Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 26, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Mt. Carmel, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 25 1966</u>	

11302

11302

Intermittent headache, right parietal

Intermittent parietal headache

14306

CERTIFICATE OF DEATH

14305

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN TB <u>25 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>9909 INGLEMEER DR</u>	
3. NAME OF DECEASED (Type or print) <u>LEA NORA</u> First <u>M</u> Middle <u>Bicicocchi</u> Last		4. DATE OF DEATH <u>10</u> Month <u>27</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1/26</u>
9. AGE (In years last birthday) <u>40</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Louis Lanuti</u>		14. MOTHER'S MAIDEN NAME <u>Louisa Lupini</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Husand</u> Address <u>Mario E. Bicicocchi</u>		Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO (b) <u>CEREBRAL METASTASES</u> DUE TO (c) <u>CARCINOMA OF BREAST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>170X</u>			INTERVAL BETWEEN ONSET AND DEATH <u>13 MIN</u> <u>1 YR</u> <u>3 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>DEC 15</u> , 19 <u>66</u> , to <u>OCT 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>OCT 26</u> , 19 <u>66</u> , and that death occurred at <u>2:20 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas F. O'Connor MD</u>		22b. DATE SIGNED <u>OCT 27, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS F. O'CONNOR MD</u>		22d. ADDRESS <u>8218 WISCONSIN AVE, BETHESDA, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-31-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 1 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14804

14306

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.	
FROM: Mr. [Name], [Address], [City], [State]	
SUBJECT: [Subject]	
RE: [Reference]	
[Body of letter]	
[Signature]	
[Date]	

FOR STATE
HEALTH DEPT.

14307

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14306

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>				d. STREET ADDRESS <u>306 Stonington Road</u>			
3. NAME OF DECEASED (Type or print) <u>Hallie Blanche Blalock</u>				4. DATE OF DEATH <u>October 10 1966</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>December 22, 1898</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u>67</u> Days <u>67</u>		IF UNDER 24 HRS. Hours <u>67</u> Min. <u>67</u>			
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>unemployed Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Granville County, N.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>James S. Jones</u>				14. MOTHER'S MARRIED NAME <u>Patricia Cozart</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>246-38-5387</u>		17. INFORMANT <u>Son-James E. Blalock</u> Address <u>306 Stonington Rd S.S. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>561.1 Acute intestinal obstruction due to</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>strangulated right femoral hernia</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				22. DATE SIGNED <u>Oct. 11, 1966</u>			
EXAMINER'S NAME (Type) <u>Belden R. Reap, Wheaton, Md.</u>				Address (Street, city, town, or county) <u>11502 Grandview Ave</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 13, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> Address <u>8434 Georgia Ave.</u>				25a. REC'D BY REGISTRAR <u>OCT 14 1966</u>			
Warner E. Pumphrey, Inc. Silver Spring, Md.				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14300

14300

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14308

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14307

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>			c. LENGTH OF STAY IN 1b <u>DOA</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital (DOA)</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>Waters</u> Last <u>Blunt</u>			4. DATE OF DEATH Month <u>10</u> Day <u>22</u> Year <u>1966</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/23/01</u>		9. AGE (In years last birthday) <u>64</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Sales Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Samuel Blunt</u>			14. MOTHER'S MAIDEN NAME <u>Emanda Waters</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-24-0012</u>		17. INFORMANT Address <u>son-in-law John A. McGrath, 18820 N.H.Ave. Ashton, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u> DUE TO (b) <u>Coronary Artery Heart Disease</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u>					INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>OCT. 23, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-25-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Goshen</u>	23d. LOCATION (City or Town) (County) (State) <u>Goshen, Mont. Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Francis H. Barber Laytonsville, Md.</u>			25a. REC'D BY REGISTRAR DATE <u>OCT 25 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14309

14308

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN TB <u>13 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>311 PINEWOOD AVE.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH G. BONSBY</u>				4. DATE OF DEATH Month Day Year <u>OCT 6 1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/30/01</u>	9. AGE (In years last birthday) <u>65</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PRIVATE SCHOOL</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN J. CLEARY</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH P. McELROY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>NONE</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>JOHN C. BONSBY-827 RICHMOND AVE. SILVER SPRING, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain tumor</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> , 19 <u>66</u> , to <u>10/6</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>66</u> , and that death occurred at <u>6:45 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert A. Mendelsohn</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/6/1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT A. MENDELSON</u>				22d. ADDRESS <u>1015 SPRING ST. - SILVER SPRING, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/11/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>WEST ROXBURY, MASS</u>	
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC. SILVER SPRING, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 10 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14310

CERTIFICATE OF DEATH

14309

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Charles Boswell</u>		4. DATE OF DEATH <u>10 30 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-17-77</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Boswell</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wilbur</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-24-0444</u>	
17. INFORMANT <u>Bessie E. Boswell - wife - same Item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Arteriosclerotic cardiovascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>6 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/24, 1966</u> , to <u>10/30, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/29, 1966</u> , and that death occurred at <u>12:15 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>A.D. Bonifant</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A.D. BONIFANT</u>		22d. ADDRESS <u>1401 Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/2/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>1331 Rock. Pike, Rodk.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE	
DATE <u>NOV 2 1966</u>			

17304

TESTIMONY OF DEATH

17310

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "TESTIMONY" and "DEATH" are visible.]

10. JOURNAL OF THE...
11. JOURNAL OF THE...
12. JOURNAL OF THE...
13. JOURNAL OF THE...
14. JOURNAL OF THE...
15. JOURNAL OF THE...
16. JOURNAL OF THE...
17. JOURNAL OF THE...
18. JOURNAL OF THE...
19. JOURNAL OF THE...
20. JOURNAL OF THE...

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14311

CERTIFICATE OF DEATH

14310

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15.1		d. STREET ADDRESS <u>9807 Broad St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Durham Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth S Brady</u> First Middle Last		4. DATE OF DEATH <u>Oct 5</u> 19 <u>66</u> Month Day Year	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/12</u>
9. AGE (In years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>28</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Columbus Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Richard Stockton</u>		14. MOTHER'S MAIDEN NAME <u>Annie L. Gollar</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband</u> Address <u>Same as Item 2.</u> <u>William Y. Brady, Jr.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>coronary atherosclerosis</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>chronic heart disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>9/22</u>		20f. (City or town) (County) (State) <u>10/5</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>9/22</u> , 19 <u>66</u> , to <u>10/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/5</u> 19 <u>66</u> , and that death occurred at <u>11 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>10/5/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>10 F Kreuzburg</u>		22d. ADDRESS <u>7852 16th Ave NW Wash DC</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-10-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1931

STATE OF NEW YORK

1931

IN SENATE

JANUARY 1, 1931

REPORT

OF THE

COMMISSIONERS

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14312

CERTIFICATE OF DEATH

14312

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY in 1b <u>17 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park Md 15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cedar Haven Rest Home Takoma Park Md</u>		d. STREET ADDRESS <u>7216 Spruce Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Philip Edward Bruscoe</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 10 1883</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash D.C.</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Philip E Bruscoe</u>		14. MOTHER'S MAIDEN NAME <u>Williamina Humphrey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-52-4586</u>	
17. INFORMANT <u>Philip E Bruscoe Jr</u>		Address <u>7216 Spruce Lane Takoma Park Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line - (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sept state Pneumonia</u> 6.05X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Cystitis</u> DUE TO (c) <u>Generalized severe Varicella Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 6, 1966</u> , to <u>Oct 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>10/1/66</u> , and that death occurred at <u>2 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. W. Meyers & H. T. Morse</u>		22b. DATE SIGNED <u>10/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. Meyers & H. T. Morse MD</u>		22d. ADDRESS <u>8323 Hadden Rd Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>10-8-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Lee Funeral Home, 300 4th St. N.E. Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 10 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3184

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14313

CERTIFICATE OF DEATH

14313

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Col. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Germantown		c. LENGTH OF STAY IN 1b 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Marylander Hursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Adelaide Last Brooke		4. DATE OF DEATH Month Oct. Day 31 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-5-1886
9. AGE (In years last birthday) 80		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Wilson		14. MOTHER'S MAIDEN NAME Helen Virginia Smith	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) - - -		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT Herbert Brooke-		Address See Item No. 2	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/1/65 , 19 65 , to 10/31 , 19 66 that (I) (we) last saw the deceased alive on 10/26 , 19 66 , and that death occurred at 4:42 PM , from causes and on the date stated above.			
22a. SIGNATURE James P. Kerr		22b. DATE SIGNED 10/31/66	
22c. PHYSICIAN'S NAME (Type) Dr. James P. Kerr		22d. ADDRESS 2661 Ridge Road, Damascus, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE THEREOF 11-2-1966	23c. NAME OF CEMETERY OR CREMATORY Warrenton Cemetery	23d. LOCATION (City or Town) (County) (State) Warrenton, Va.
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.		25a. REC'D BY REGISTRAR NOV 3 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2164

1000

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb <u>22 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>		d. STREET ADDRESS <u>9002 Westmoreland Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Henry Rhodes Brown</u>		4. DATE OF DEATH Month Day Year <u>October 15 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-14-94</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Government worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Chester Brown</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Rhodes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WW I Army</u>		16. SOCIAL SECURITY NO. <u>216-22-1076-A</u>	
17. INFORMANT <u>Records - Washington Sanitarium & Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1621 Bronchopneumonia</u> DUE TO (b) <u>Bacterial Infection</u> DUE TO (c) <u>Bronchiogenic Carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>hours</u> <u>days</u> <u>months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/23</u> , 19 <u>66</u> , to <u>10/15</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>10/15</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Kenneth Cruze</u>		22b. DATE SIGNED <u>10/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>KENNETH CRUZE</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Oct 17, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery, Prince Georges Co. Md</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		25c. DATE <u>OCT 18 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14315

CERTIFICATE OF DEATH

14315

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 23 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS RT. 3 Box 193	
3. NAME OF DECEASED (Type or print) First MELVIN Middle RUSSELLE Last BURDETTE		4. DATE OF DEATH Month OCTOBER Day 31 Year 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/05
9. AGE (In years last birthday) 61 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY SELF-EMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME LUTHER BURDETTE		14. MOTHER'S MAIDEN NAME ELLA CUTSAIL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-28-7981	
17. INFORMANT HOSPITAL RECORDS		Address OLNEY, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinomatosis - probable pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 6 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 19 66 to Oct. 31 , 19 66 , that (I) (we) last saw the deceased alive on 10-29 19 66 , and that death occurred at 9:40 M, from causes and on the date stated above.			
22a. SIGNATURE Frederick Moomau M.D.		22b. DATE SIGNED 10-31-66	
22c. PHYSICIAN'S NAME (Type) FREDERICK MOOMAU, M.D.		22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/3/66	23c. NAME OF CEMETERY OR CREMATORY Hyattstown Methodist	23d. LOCATION (City or Town) (County) (State) Hyattstown Montg. Md.
24. FUNERAL DIRECTOR Tyson Wheeler		25a. REC'D BY REGISTRAR NOV 2 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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COUNTY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b Chevy Chase	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda Silver Spring Nursing Home		d. STREET ADDRESS 4701 Willard Ave.	
3. NAME OF DECEASED (Type or print) First Dwight Middle Nutting Last Burnham		4. DATE OF DEATH Month Oct. Day 23 Year 1966	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/23/1885
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 15 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Private	
11. BIRTHPLACE (County & State, or foreign country) Beatrice, Nebraska		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oliver R. Burnham		14. MOTHER'S MAIDEN NAME Harriett Nutting	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT A. deMouy Spottswood Chevy Chase, Md.		18. INTERVAL BETWEEN ONSET AND DEATH 10 years	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROSIS, GENERALIZED DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIOSCLEROSIS DUE TO (c) ASHD & HEART FAILURE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 Oct. 23 , 19 66 that (I) (we) last saw the deceased alive on 10-23 19 66 , and that death occurred at 3 P M, from causes and on the date stated above.			
22a. SIGNATURE Philip R. James		22b. DATE SIGNED 10-23-66	
22c. PHYSICIAN'S NAME (Type) PHILIP R. JAMES		22d. ADDRESS Washington Clinic, D.C.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 10/24/66	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Prince Georges Co. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR JOSEPH GAULER SONS WASH. D.C.		25a. REC'D BY REGISTRAR OCT 27 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14317

CERTIFICATE OF DEATH

14317

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>12 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> d. STREET ADDRESS <u>9119 RIVER ROAD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES H. CARRICO</u>		4. DATE OF DEATH Month Day Year <u>OCT 3 19 66</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/25/81</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SELF EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RIDING STABLE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>HENRY William CARRICO</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH BROOKS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>22.0-32-5847</u>	
17. INFORMANT <u>MAE CARRICO - WIFE - SAME</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Metastatic Kidney Invasion</u> DUE TO (c) <u>Ca Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 WK</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/21</u> , 19 <u>66</u> to <u>10/3</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/3</u> , 19 <u>66</u> and that death occurred at <u>10:45</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Robert G. Brewer</u> M.D.		22b. DATE SIGNED <u>10/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert G. Brewer</u>		22d. ADDRESS <u>8505 Old Geo. Town Rd. Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>6 Oct 66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Md</u>
24. FUNERAL DIRECTOR <u>Joseph Gawlers Sons</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>WASH. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
5130 Wisc Ave NW		DATE <u>OCT 7 1966</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14318					14318						
1. PLACE OF DEATH e. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b 5 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			d. STREET ADDRESS 9702 Carriage Road			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9702 Carriage Road					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) MARY V. CASSIDY					4. DATE OF DEATH Month OCTOBER Day 31 Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH Feb. 28, 1896		9. AGE (In years last birthday) 70 yrs.			
								IF UNDER 1 YEAR Months 8 Days 3			
								IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME Ward V. Coates					14. MOTHER'S MAIDEN NAME Elizabeth J. Quinn						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) Unknown		17. INFORMANT Husband Norwood P. Cassidy		Address Same as Item 2.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOVASCULAR COLLAPSE 157X DUE TO Conditions, if any, which gave rise to immediate cause (b) carcinomatosis gen'l (c) carcinoma of pancreas (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH 1 hr 8 months 1 yr	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) operated 2 min						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 10/30/66 to 10/31/66 , that (I) (we) last saw the deceased alive on 10/30/66 , and that death occurred at 8 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Charles Savarese, M.D.					22b. DATE SIGNED 10/31/66						
22c. PHYSICIAN'S NAME (Type) CHARLES SAVARESE, MD					22d. ADDRESS 11125 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-3-66		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland					
24 FUNERAL DIRECTOR'S SIGNATURE ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR DATE NOV 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

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NO. 10012

W. H. H. H.

W. H. H. H.

State of New York

1-7-76

W. H. H. H.

NOV 1 1988

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14319

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Virginia</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>48 hr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8200 Wisconsin Ave.</u>				d. STREET ADDRESS <u>411 Crownview</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANN OPIE CHANCELLOR</u>				4. DATE OF DEATH <u>Oct. 22 1966</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/1/44</u>	
9. AGE (In years lost birthday) <u>22</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>AL OPIE CHANCELLOR</u>				14. MOTHER'S MAIDEN NAME <u>ROTH A HOLZ MUELLER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-601288</u>		17. INFORMANT <u>Dr. David Anderson N14</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>978X Compression. Cervical. Cord.</u> DUE TO (b) <u>Arterio-sclerosis - from Fall - 11 stories -</u> DUE TO (c) <u>Arterio-sclerosis - from Fall - 11 stories -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped down Elevator Shaft 11th Floor.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> o.m. <u>10 22</u> 19 <u>66</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Building</u>		20f. (City or town) <u>Bethesda</u> (County) <u>Mont.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Bell</u> M.D.				22. DATE SIGNED <u>10/24/66</u>			
EXAMINER'S NAME (Type) <u>John S. Bell</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>1500 W. Braddock Rd. Alexandria, Va.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Milford, Delaware</u>	
24. FUNERAL DIRECTOR <u>Everly-Wheatley Funeral Home, Alexandria, Va.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>OCT 27 1966</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14320

CERTIFICATE OF DEATH

14320

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase	
c. LENGTH OF STAY IN 1b 7 Months 28 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethesda-Silver Spring Nursing Home		d. STREET ADDRESS 4104 Rosemary Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALICE Middle S. Last CHRISTIAN		4. DATE OF DEATH Month Oct. Day 14 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 29, 1896
		9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months 1 Days 15 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Upshur Snider		14. MOTHER'S MAIDEN NAME Mary Robbins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Daughter Address Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emphysema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Healed pulmonary tuberculosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atherosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 19, 1962 to Oct 14, 1966 that (I) (we) last saw the deceased alive on October 14, 1966 , and that death occurred at 10:35 AM , from causes and on the date stated above.			
22a. SIGNATURE Thomas S. Sappington M.D.		22b. DATE SIGNED 10-14-66	
22c. PHYSICIAN'S NAME (Type) THOMAS S. SAPPINGTON		22d. ADDRESS 2233 Wisconsin Ave., N.W. Washington, D. C.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial-transit	10-15-66	Highland Cemetery	Iola, Kansas
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 19 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14321

CERTIFICATE OF DEATH

14321

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chevy Chase		c. LENGTH OF STAY IN 1b Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7113 W. Greenvale Parkway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN H. CLAGETT, JR		4. DATE OF DEATH Month Oct. Day 31 Year 19 66	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1, 1896
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Clagett		14. MOTHER'S MAIDEN NAME Sophie Hohman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		16. SOCIAL SECURITY NO. 214-03-0555	
17. INFORMANT Address John H. Clagett III, Same as #2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Pyelonephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May, 1963 , to 10-31, 1966 , that (I) (we) last saw the deceased alive on 10-24 1966 , and that death occurred at 11:05 PM , from causes and on the date stated above.			
22a. SIGNATURE Charles G. Smith		22b. DATE SIGNED 11-1-66	
22c. PHYSICIAN'S NAME (Type) Charles G. Smith M.D.		22d. ADDRESS 4615 Lee Highway Arlington, Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/3/66	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Washington, D.C.		25a. REC'D BY REGISTRAR NOV 7 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEATH OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14322

CERTIFICATE OF DEATH

14322

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN TB <u>36 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>10110 GEORGIA AVENUE</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Roy W. CLARK</u>		4. DATE OF DEATH Month Day Year <u>OCT. 31 1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-24-1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Stripping & Screening Clark Manufacturers</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Iowa</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Benjamin Clark</u>		14. MOTHER'S MAIDEN NAME <u>Eva Worrell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No None</u>		16. SOCIAL SECURITY NO. <u>218-16-0111</u>	
17. INFORMANT <u>Belle Clark</u>		Address: <u>10110 Georgia Avenue Silver Spring, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral metastasis</u> DUE TO (b) <u>Cancer colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>38 days</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 25, 1966</u> to <u>Oct 31, 1966</u> , that (I) (we) lost saw the deceased alive on <u>Oct 30, 1966</u> , and that death occurred at <u>6:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Richards</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Edward J. Richards</u>		22b. DATE SIGNED <u>Oct 31, 1966</u>	
22d. ADDRESS <u>10110 Georgia Avenue, S. S., Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2 Nov 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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Items 18&21 Film 383 12-13-66 ans									
MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Suburban</i> c. LENGTH OF STAY IN lb <i>DOA</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kensington</i> d. STREET ADDRESS <i>10125 Thornebrook Rd</i> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>STEPHEN SHAWN CLARKE</i>					4. DATE OF DEATH <i>Oct 13 1966</i>		5. SEX <i>M</i>		
6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 21 1966</i>		9. AGE (In years last birthday) <i>3</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Infant</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>		
13. FATHER'S NAME <i>CHARLES CLARKE</i>					14. MOTHER'S MAIDEN NAME <i>Mary Ely Boyd</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>-</i>					16. SOCIAL SECURITY NO. <i>-</i>		17. INFORMANT <i>Father - same as above</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia (SDII)</i> 922.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>-</i> DUE TO (c) <i>-</i>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Belden R. Reap</i>					22. DATE SIGNED <i>Oct. 13, 1966</i>				
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>					DEPUTY MEDICAL EXAMINER <i>Wheaton MD</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>10-14-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>State of Heaven</i>		23d. LOCATION (City, town or county) (State) <i>Wheaton MD</i>			
24. FUNERAL DIRECTOR <i>B. HANLON</i>					25a. REC'D BY REGISTRAR <i>4748 NW 5C</i>		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>		
					DATE <i>10-15-66</i>		<i>OCT 20 1966</i>		

1938

OFFICIAL EXAMINER'S CERTIFICATE OF DEATH

1938

Blank form with horizontal lines for text entry.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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14324												14324																							
1. PLACE OF DEATH a. COUNTY Montgomery						MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND						b. COUNTY MONTGOMERY																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK						c. LENGTH OF STAY IN 1b 4 DAYS						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING						15-1																	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON SANITARIUM AND HOSP.						9907 CAPITOL VIEW AVE.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) First CHARLES						Middle ROSS						Last CLEAVES						4. DATE OF DEATH Month OCT.						Day 12						Year 1966					
5. SEX MALE				6. COLOR OR RACE WHITE				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH JULY 2, 1895				9. AGE (In years lost birthday) 71 yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Landscape Gardener						10b. KIND OF BUSINESS OR INDUSTRY Landscaping						11. BIRTHPLACE (State or foreign country) Virginia						12. CITIZEN OF WHAT COUNTRY? U. S. of American																	
13. FATHER'S NAME Mr. Iron Cleaves						14. MOTHER'S MAIDEN NAME Elizabeth Pollard																													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes						16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW 1 Army 577-09-1030						17. INFORMANT Mrs. Leafy L. Cleaves						Address 9904 Capitol View Ave. Silver Spring, Md.																	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA URINARY BLADDER 1510 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 7 MONTHS																							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY EMPHYSEMA AND RIGHT INGUINAL HERNIA												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.						20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>						20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from Nov. 18, 1965, to OCT. 12, 1966 that (1) (we) last saw the deceased alive on OCT. 12, 1966 and that death occurred at 12:40 AM, from the causes and on the date stated above.																																			
22a. SIGNATURE James A. Roberts												M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22b. DATE SIGNED OCT. 12, 1966											
22c. PHYSICIAN'S NAME (Type) JAMES A. ROBERTS												22d. ADDRESS 8907 GEE. AVE. SILVER SPRING, MD.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial						23b. DATE THEREOF Oct. 15, 1966						23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery						23d. LOCATION (City, town, or county) (State) Mt. Williams, Virginia																	
24. FUNERAL DIRECTOR'S SIGNATURE Glen Carter												ADDRESS Colonial 8434 Georgia Ave. Warner E. Purphrey, Inc. Silver Spring, Md.												25a. REC'D BY REGISTRAR DATE OCT 17 1966						25b. REGISTRAR'S SIGNATURE J Charles Judge					

14354

CERTIFICATE OF DEATH

14354

Blank certificate form with horizontal lines for text entry.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

14325

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14325

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash Sant Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> d. STREET ADDRESS <u>3009 Winifred Dr</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ralph Eugene Cochran</u> First Middle Last 4. DATE OF DEATH <u>10 15 1966</u> Month Day Year				9. AGE (In years last birthday) <u>34</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-15-32</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pro Les. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Ralph Eugene Cochran</u>				14. MOTHER'S MAIDEN NAME <u>Helen Alberta Jewell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-24-2303</u>		17. INFORMANT <u>Carolyn F. Cochran</u> Address <u>Burtonsville, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330X Massive subarachnoid Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>due to rupture of intracranial</u> DUE TO (c) <u>artery near Circle of Willis</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Read</u> EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		22. DATE SIGNED <u>Oct. 16, 1966</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Prince Md</u>	
24. FUNERAL DIRECTOR <u>F. Guske's sons</u> ADDRESS <u>Hyattsville Md</u>				25a. REC'D BY REGISTRAR <u>Oct 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1438

1438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14326

CERTIFICATE OF DEATH

14326

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>College Park</u>		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>5904 Bryn Mawr Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>C.</u> Last <u>Colister</u>				4. DATE OF DEATH Month <u>October</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 10, 1895</u>	9. AGE (In years last birthday) <u>70 26</u> yrs.	10. IF UNDER 1 YEAR Months <u>10</u> Days <u>26</u> Hours <u>0</u> Min. <u>0</u>		11. IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Slavin</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>220-30-1476</u>		17. INFORMANT <u>John R. Colister</u> Address <u>5904 Bryn Mawr Road College Park, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Insufficiency</u> DUE TO <u>Arteriosclerotic Cardiovascular Disease & Congestive Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease & Congestive Failure</u> (c) <u>Arteriosclerotic Cardiovascular Disease & Congestive Failure</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>Oct</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-17</u> , 19 <u>66</u> , and that death occurred at <u>4:30</u> A.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Bernard A. Fitzgerald</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-17-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A. FITZGERALD</u>				22d. ADDRESS <u>Silver Spring, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 19, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Maryland</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>John B. Thomas</u> 8434 Georgia Avenue <u>Warner E. Pumphrey, Inc.</u> Silver Spring, Md.				25a. REC'D BY REGISTRAR DATE <u>OCT 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 5 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GERMAN TOWN		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS NONE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELMER Middle EDWIN Last COLLINS		4. DATE OF DEATH Month 10 Day 19 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-90
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER & PAINTER RETIRED		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES A. COLLINS		14. MOTHER'S MAIDEN NAME SARAH UNGLESBEE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-18-8350	
17. INFORMANT MEDICAL RECORDS DEPT.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rupture Lt. anterior Cerebral artery hours (c) Hypertensive Cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10-19, 1966 , to 10-19, 1966 , that (I) (we) last saw the deceased alive on 10-19, 1966 , and that death occurred at 2:30 M, from causes and on the date stated above.			
22a. SIGNATURE Jack Schumacher M.D.		22b. DATE SIGNED 10-20-66	
22c. PHYSICIAN'S NAME (Type) JACK SCHUMACHER, M. D.		22d. ADDRESS GAITHERSBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-22-66	23c. NAME OF CEMETERY OR CREMATORY Neelsville	23d. LOCATION (City or Town) (County) (State) German town Montg Md.
24. FUNERAL DIRECTOR Ernest C. Gartner Address Gaithersburg, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE OCT 24 1966	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office, along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File, pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14328

14328

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville c. LENGTH OF STAY IN 1b Rockville d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6902 Tilden Lane				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 6902 Tilden Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MAUDE F. COLLINS First Middle Last				4. DATE OF DEATH Oct. 7, 1966 Month Day Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 Nov. 1885	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, D.C.	
13. FATHER'S NAME George E. Fletcher				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 220-46-3827		17. INFORMANT MGen. Wm. R. Collins Address 4107 Dakota Ct. Alexandria, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency Acute 4201 OUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardio Vascular Disease - DUE TO (c) chronic.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> -10/8/66 Address (Street, city, town, or county)			
EXAMINER'S NAME (Type) John G. Ball				22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/66		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City, town or county) (State) Prince George Co., Md.	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.				25a. REC'D BY REGISTRAR DATE OCT 11 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14329

CERTIFICATE OF DEATH

14329

1. PLACE OF DEATH a. COUNTY <u>Montgomery Co. Silver Spring</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Colonial Villa Nursing Home</u>		d. STREET ADDRESS <u>816 Philadelphia Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>NELLIE</u> Middle <u>A.</u> Last <u>COLLINS</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/20/85</u>
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>11</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Greenleaf, Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hugh Thorman</u>		14. MOTHER'S MAIDEN NAME <u>Amelia S. Hobby</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>570-16-6432</u>	
17. INFORMANT <u>Hugh Reynolds Collins</u>		Address <u>4908 Quaton Street College Park, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral atherosclerosis & CVA</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>66</u> , to <u>Oct. 31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 26</u> , 19 <u>66</u> , and that death occurred at <u>6:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Mani Schuch</u>		22b. DATE SIGNED <u>10/31/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Mani Schuch</u>		22d. ADDRESS <u>911 Silver Spring Ave, S.S. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3 Nov 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>NOV 4 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>		25c. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>	

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INSTITUTE OF HEALTH

Myocardial Infarction

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Cardinal other colonias 2 A22

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All Silver Spring, Md.
July 22, 1952

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14330

CERTIFICATE OF DEATH

14330

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY Stafford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 mos. 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Harry Last Collins		4. DATE OF DEATH Month Oct. Day 21 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1910
9. AGE (In years lost birthday) yrs. 55		10. IF UNDER 1 YEAR Months 21 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USMC		10b. KIND OF BUSINESS OR INDUSTRY Collins Georgia	
11. BIRTHPLACE (County & State, or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Z. C. Collins		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1931-1953		16. SOCIAL SECURITY NO. 1931-1953	
17. INFORMANT Stafford		Address Va. Mrs. Edith Collins, Route 2, Box 205	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage, massive, lung 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchogenic carcinoma DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (a) (this hospital) attended the deceased from July 18 , 19 66 , to Oct. 21 , 19 66 , that (b) (we) last saw the deceased alive on Oct. 21 , 19 66 , and that death occurred at 730A M, from causes on and on the date stated above.			
22a. SIGNATURE Robert J. Kinney, M.D.		22b. DATE SIGNED Oct. 21, 1966	
22c. PHYSICIAN'S NAME (Type) Robert J. Kinney, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-24-66	23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Cemetery	23d. LOCATION (City or Town) (County) (State) Fredricksburg, Va.
24. FUNERAL DIRECTOR Robert A. Pumphrey 7557 Wisconsin Ave., Bethesda, Md.		25a. REC'D BY REGISTRAR DATE OCT 25 1966	
25b. REGISTRAR'S SIGNATURE f Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14331

CERTIFICATE OF DEATH

14331

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN TB <i>3 days</i> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium and Hospital</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> d. STREET ADDRESS <i>614 Ridge Rd. S.E.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Joseph Norman Colton</i>		4. DATE OF DEATH Month Day Year <i>Oct 7 1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-14-92</i>
9. AGE (In years last birthday) <i>74 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Civil Service</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Frank Johnson Colton</i>		14. MOTHER'S MAIDEN NAME <i>Marie P. Delahay</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> <i>1621</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <i>bronchogenic carcinoma</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		INTERVAL BETWEEN ONSET AND DEATH <i>more than 6 months</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept. 20, 1966</i> to <i>Oct. 7, 1966</i> , that (I) (we) last saw the deceased alive on <i>Oct. 7, 1966</i> , and that death occurred at <i>12:30</i> P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Charles Hrisi Kapaules</i>		22b. DATE SIGNED <i>Oct. 7, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Charles Hrisi Kapaules MD</i>		22d. ADDRESS <i>Washington Sanitarium and Hosp. Takoma Park, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 10, 1966</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Josephs</i>		23d. LOCATION (City or Town) (County) (State) <i>Morganza, Maryland</i>	
24. FUNERAL DIRECTOR <i>W. Clarke Mattingley Leonardtown, Maryland</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>OCT 11 1966</i>	

14331

RECEIVED OF BIRTH

14331

received

10.10.1900
J. J. J. J.
J. J. J. J.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14332

Item 23b Film G381 10/20/66 mh

CERTIFICATE OF DEATH

14332

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 81 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville		16-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 7603 Inwood Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Walter E. CROLL		4. DATE OF DEATH October 11, 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1892
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Muscian		10b. KIND OF BUSINESS OR INDUSTRY U.S. Navy	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME William Croll		14. MOTHER'S MAIDEN NAME Sarah Mumie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO.	
17. INFORMANT Hyattsville Address Maryland Mrs. Charlotte Croll, 7603 Inwood Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure 5271 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Pulmonary Emphysema DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cardiac Vascular Accident			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if this hospital) attended the deceased from July 22, 1966 , to Oct. 11, 1966 that (1) (we) last saw the deceased alive on Oct. 11, 1966 , and that death occurred at 220AM , from causes on and on the date stated above.			
22a. SIGNATURE Robert J. Kinney		22b. DATE SIGNED 11 Oct. 1966	
22c. PHYSICIAN'S NAME (Type) R. J. KINNEY, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/13/66	23c. NAME OF CEMETERY OR CHURCH Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR Francis Gasch's Sons ADDRESS 4739 Baltimore Ave., Hyattsville, Md.		25a. REC'D BY REGISTRAR DATE OCT 17 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1998

2832

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Items 18&21 Film 384 1-19-67 gms

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14333

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14333

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
c. LENGTH OF STAY IN 1b <u>60 days</u>		d. STREET ADDRESS <u>9315 Weaver Street</u>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Marietta</u> Last <u>Curtiss</u>		4. DATE OF DEATH Month <u>October</u> Day <u>31</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 19, 1883</u>	
9. AGE (In years last birthday) <u>83 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Typist U.A.</u>		
11. BIRTHPLACE (State or foreign country) <u>Mass.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>(Unknown) Parsons</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Johnson</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>217-52-6437</u>		
17. INFORMANT <u>Dwight Curtiss</u>		Address <u>9315 Weaver Street Silver Spring, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Acute massive pulmonary embolus</u> <u>465x</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County)		(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>Nov. 2, 1966</u>
EXAMINER'S NAME (Type) <u>Belden R. Reap Wheaton, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1502 Grandview Ave.</u>		Address (Street, city, town, or county)
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 3, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>
23d. LOCATION (City, town or county) <u>Arlington, Va.</u>		23e. REC'D BY REGISTRAR <u>John B. Thomas</u>		
23f. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		23g. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
23h. ADDRESS <u>34 Georgia Ave.</u>		23i. DATE <u>NOV 4 1966</u>		
23j. CITY, STATE, ZIP <u>Silver Spring, Md.</u>		23k. ZIP <u>20910</u>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 7, 13, 23c Film G382 11/15/66 mh

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

14334

14334

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and Page 4 event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY MONTGOMERY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING		c. LENGTH OF STAY IN 1b 72		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE OHIO		b. COUNTY HAMILTON	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL				d. STREET ADDRESS 2302 NORWOOD AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LORETTA		First FAY		Middle DENMAN		Last DENMAN		4. DATE OF DEATH Month 10 - Day 16 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-29-86	9. AGE (In years lost birthday) yrs. 80	IF UNDER 1 YEAR Months 10 Days 16		IF UNDER 24 HRS. Hours 16 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Eli Carleton				14. MOTHER'S MAIDEN NAME Anetta Means					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 301-05-6355		17. INFORMANT Address Rockville MRS. ELSIE SOMMER, dght. 14312 OAKVALE ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute Coronary Insufficiency (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Belden R. Reap		EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED OCT. 16, 1966	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 10/19/66		23c. NAME OF CEMETERY OR CREMATORY Beth Haven Memorial Park		23d. LOCATION (City or Town) (County) (State) Cincinnati, Ohio			
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike				25a. REC'D BY REGISTRAR DATE OCT 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

14534

14534

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18&21 Film 382 11-14-66 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14335

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14335

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b 4 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 1610 Drexel St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle B. Last Dierks				4. DATE OF DEATH Month October Day 4 Year 19 66			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/7/61	
9. AGE (In years last birthday) 5 yrs		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHILDO				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OHIO	
13. FATHER'S NAME Max M. Dierks				14. MOTHER'S MAIDEN NAME Janet Reid Vivian Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT HOSP. RECORDS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest, 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) unknown etiology DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap EXAMINER'S NAME (Type) BELDEN R. REAP M.D.				22. DATE SIGNED Oct. 5, 1966			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct 10, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR 254 Carroll St NW				ADDRESS WASH DC		25a. REC'D BY REGISTRAR DATE OCT 10 1966	
				25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14336

CERTIFICATE OF DEATH

14336

1. PLACE OF DEATH a. COUNTY Montgomery <div style="text-align: right;">MARYLAND</div>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)			c. LENGTH OF STAY IN 1b 1 hour		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 10009 Hurst Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Baby Middle Boy Last DOLAN				4. DATE OF DEATH Month October Day 9 Year 19 66			
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1966		9. AGE (In years last birthday) yrs. 1	IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Montgomery, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael F. Dolan				14. MOTHER'S MAIDEN NAME Loretta Ann Young			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	17. INFORMANT Bethesda, Address Maryland Dr. Michael F. Dolan, 10009 Hurst St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gross immaturity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Oct. 9, 1966 , to Oct. 9, 1966 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Oct. 9, 1966 , and that death occurred on Oct. 9, 1966 at 1010 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>A. E. Tompkins</i>				22b. DATE SIGNED Oct. 12, 1966		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) A. E. Tompkins, M. D.				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-66		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City or Town) (County) (State) New York City, New York	
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Funeral Home, 7557 Wisconsin Ave., Bethesda, Maryland				25a. REC'D BY REGISTRAR DATE OCT 13 1966		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14338

STATE OF TEXAS

14338

(Name)

(Address)

(City)

(County)

(State)

(Zip)

(Phone)

(Fax)

(E-mail)

(Web)

(Social Media)

(Other)

(Signature)

(Date)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14337

CERTIFICATE OF DEATH

14337

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY --			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium				d. STREET ADDRESS 3723 Jenifer St., N. W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Proctor Middle L. Last Dougherty				4. DATE OF DEATH Month Oct. Day 15 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9. 1873		9. AGE (In years last birthday) 93 yrs.	10. IF UNDER 1 YEAR Months 15 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Mass.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Michael A. Daugherty				14. MOTHER'S MAIDEN NAME Mary Elizabeth Proctor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 579-44-1927		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, Terminal DUE TO (b) Leukemia, lymphatic, chronic DUE TO (c) Arteriosclerosis, generalised						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 7 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1950 , to OCT 15 , 19 66 , that (I) (we) last saw the deceased alive on OCT 14 , 19 66 , and that death occurred at 5:40 P.M. from causes on and on the date stated above.							
22a. SIGNATURE Stewart Clapp M.D.				22b. DATE SIGNED 10-15-66		22c. PHYSICIAN'S NAME (Type) Stewart Clapp M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF 10/16/66		23c. NAME OF CEMETERY OR CREMATORY Lees Crematory	
24. FUNERAL DIRECTOR J. Wm. Lees Sons				25a. REC'D BY REGISTRAR OCT 18 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	
23d. LOCATION (City or Town) Washington				23e. (County) D. C.		23f. (State) D. C.	

75911

15347

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1

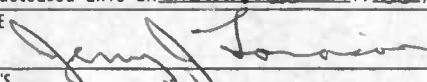

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14338

Item #23c Film #G382 11/1/66 pc

CERTIFICATE OF DEATH

14338

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 9 Coral Place	
3. NAME OF DECEASED (Type or print) Jay Aloy Dubert		4. DATE OF DEATH Month Oct. Day 16 Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 5, 1966
9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 11 Days 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Patuxent River, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard C DUBERT		14. MOTHER'S MAIDEN NAME Bonnie Lee MEKUS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Park, Md.		Address Richard C. Dubert, 9 Coral Pl. Lexington	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomembranous enterocolitis with fibro 5710 DUE TO purulent peritonitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Oct. 16, 1966 , to Oct. 16, 1966 that (1) (we) last saw the deceased alive on Oct. 16, 1966 , and that death occurred at 8:10 AM , from causes and on the date stated above.			
22a. SIGNATURE  M.D.		22b. DATE SIGNED Oct. 17, 1966	
22c. PHYSICIAN'S NAME (Type) Jerry J. Tomasovic, M.D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) transit-burial		23b. DATE THEREOF 10-18-66	
23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) Dunkirk, N.Y.	
24. FUNERAL DIRECTOR Robert A. Pumphrey ADDRESS Md.		25a. REC'D BY REGISTRAR DATE OCT 20 1966	
Funeral Home, 7557 Wisconsin Ave. Bethesda/		25b. REGISTRAR'S SIGNATURE 	

6-22443-6

14338

STATE OF TEXAS

14338

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN
RECEIVED BY THE STATE OF TEXAS AND IS NOW A RESIDENT OF
THE COUNTY OF DALLAS, TEXAS.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14339

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14339

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural German town.</u>		c. LENGTH OF STAY IN 1b <u>141.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Snyders Trailer Haven.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lawrence Ege.</u>		4. DATE OF DEATH <u>Oct. 21 1966.</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 19, 1916</u>
9. AGE (In years last birthday) <u>50 yrs</u>		IF UNDER 1 YEAR: Months <u>50</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Washington, Dc.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, Dc.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lewis Ege</u>		14. MOTHER'S MAIDEN NAME <u>Helen Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>231-18-9602</u>	
17. INFORMANT <u>Mary Loy Ege. As #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - acute.</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4201</u> (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22. DATE SIGNED <u>10/21/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-25-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Massachusetts</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodstock Va.</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> ADDRESS <u>Gaithersburg, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 25 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11330

3

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G382 11/21/66 mh

14341

CERTIFICATE OF DEATH

14342

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or entombment, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San + Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville, Md. Silver Spring</u> d. STREET ADDRESS <u>2308 Colston Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Minnie</u> Middle <u>Barton</u> Last <u>Elder</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-3-91</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>75</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>American</u>	
13. FATHER'S NAME <u>Harry Mankin</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Dent</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-50-9311</u>	
17. INFORMANT <u>med records</u>		Address <u>W.S.H.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Coronary Artery Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Artery atherosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>2 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19<u>64</u>, to <u>3 Oct.</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>3 October 1966</u> and that death occurred on <u>3 Oct</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Morrill C. Quinnam Jr.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-5-66</u>
22c. PHYSICIAN'S NAME (Type) <u>MORRILL QUINNAM</u>		22d. ADDRESS <u>831 Univ. Blvd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>6 Oct 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>JOSEPH CRAWLERS SONS</u>		ADDRESS <u>5130 WISCONSIN AVE NW</u> <u>WASHINGTON D.C.</u>	25a. REC'D BY REGISTRAR <u>DATE OCT 7 1966</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

2251

2321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

138

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14340

CERTIFICATE OF DEATH

14340

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>		c. LENGTH OF STAY IN 1b <u>20 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHEVY CHASE</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7731 ROCTON COURT</u>		d. STREET ADDRESS <u>7731 ROCTON COURT</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ESTHER</u> First Middle Last		4. DATE OF DEATH <u>OCT.</u> Month Day Year <u>4</u> 19 <u>66</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 3, 1896</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>RUSSIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LOUIS KOENICK</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>DR. BLAINE FIG (SON)</u>		Address <u>7731 ROCTON COURT</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>2 YRS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>DIABETES MELLITUS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> , 19 <u> </u> , to <u>OCT. 4</u> , 19 <u>66</u> that (I) (<u>we</u>) last saw the deceased alive on <u>OCT. 3</u> 19 <u>66</u> , and that death occurred at <u>1 P.</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Saul Zukerman</u>		22b. DATE SIGNED <u>10-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>SAUL ZUKERMAN</u>		22d. ADDRESS <u>5410 CONNECTICUT AVE N.W.</u>	
23a. BURIAL, CREMATION, or other final disposition <u>BURIAL</u>		23b. DATE THEREOF <u>10-5-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>BNAI ISRAEL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>OXON HILL, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>BERNARD DANZANSKY & SONS WASHINGTON DC</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 7</u> 19 <u>66</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11334

UNITED STATES DEPARTMENT OF AGRICULTURE

11334

UNITED STATES DEPARTMENT OF AGRICULTURE

10-5-66

11334

11334

UNITED STATES DEPARTMENT OF AGRICULTURE

11334

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or reburial, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14342

CERTIFICATE OF DEATH

14341

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Virginia b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Arlington		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Naval Hospital, Bethesda, Maryland				d. STREET ADDRESS 421 North Monroe Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sandra Louise ELIOT				4. DATE OF DEATH Month Day Year October 15 19 66			
5. SEX Female		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 30 May 1952	
9. AGE (In years last birthday) 14 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student				10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (County & State, or foreign country) Monterey, California	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Joe ELIOT				14. MOTHER'S MAIDEN NAME Luz Goenaga			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) N/A		16. SOCIAL SECURITY NO. N/A		17. INFORMANT 421 North Monroe St. Joe ELIOT, CAPT/USN Arlington, Virginia			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia Gram Negative Aplastic Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 5 October 19 66 to 15 October 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 15 October 19 66 , and that death occurred at 541P M, from causes and on the date stated above.							
22a. SIGNATURE Merlin G. Otteman				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 16 October 1966	
22c. PHYSICIAN'S NAME (Type) Merlin G. OTTEMAN, LCDR MC USNR				22d. ADDRESS U.S. Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey				25a. REC'D BY REGISTRAR Bethesda, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 20 1966							

14841

14841

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

REPORT OF THE COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 1, 1899

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS, 1899.

STATE OF NEW YORK

IN SENATE

JANUARY 1, 1901

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IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

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REPORT OF THE COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE

APRIL 1, 1899

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS, 1899.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14343

CERTIFICATE OF DEATH

14343

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA-SILVER SPRING		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA-SILVER SPRING NURSING HOME		d. STREET ADDRESS 8207 GRUBB ROAD	
3. NAME OF DECEASED (Type or print) First Middle Last EVA ETELSON		4. DATE OF DEATH Month Day Year OCTOBER 3, 1966	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	
11. BIRTHPLACE (County & State, or foreign country) LITHUANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABBA POSNER		14. MOTHER'S MAIDEN NAME SHANA RIVA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT MRS. RENA BECKER		Address TAKOMA PARK, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL THROMBOSIS DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 WK 6 MOS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from APRIL , 19 66 to 3 OCT , 19 66 , that (I) (we) last saw the deceased alive on 3 OCT 19 66 , and that death occurred at 4:30 M, from causes and on the date stated above.			
22a. SIGNATURE WALTER E. GOOZH MD		22b. DATE SIGNED 3 OCT 66	
22c. PHYSICIAN'S NAME (Type) WALTER E. GOOZH MD		22d. ADDRESS 2390 GLENMONT CIR WHEATON MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/5/66	23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN		25. REC'D BY REGISTRAR DATE OCT 5 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

RESTORE

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14344

CERTIFICATE OF DEATH

14344

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6307-14th Street, N.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Joan R.</u> Middle <u>Farrar</u> Last <u>Farrar</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>6/23/25</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>	
13. FATHER'S NAME <u>John R. Farrar</u>		14. MOTHER'S MAIDEN NAME <u>Robert A. Becker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Mrs. Roberta B. Farrar, Mother</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2710</u> DUE TO <u>Cardiac Arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyperparathyroidism</u> (c) <u>Parathyroid Adenoma</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/6</u> , 19 <u>66</u> to <u>10/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Edgar H. Levi</u>		22b. DATE SIGNED <u>10/14/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDGAR H. LEVI</u>		22d. ADDRESS <u>8218 Wisconsin Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct 18, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Brooklyn, New York</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Wash. DC</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 19 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11311

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14345

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14345

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Damascus</u>		c. LENGTH OF STAY IN 1b <u>4 Yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Damascus</u> <u>15.1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route B - Mt Airy Dewy Brown Farm</u>				d. STREET ADDRESS <u>Route - 3 Mt Airy Dewy Brown Farm</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Custer</u> Last <u>Fawsett</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 26 1908</u> 58 Yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cattle Dealer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Howard C. Fawsett</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Miss Elizabeth Fawsett, Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Insufficiency Acute</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. — p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John G. Ball</u>		EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>10/19/66</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 22, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1937-1

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14346

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14346

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b <u>3 hrs.</u>		d. STREET ADDRESS <u>10201-Grosvener Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ethel Wagner Feldherr</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 30, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Romania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Schacker</u>		14. MOTHER'S MAIDEN NAME <u>Frema Wagner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-48-9541</u>	
17. INFORMANT <u>Lew Feldherr</u>		Address <u>5400 Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis - Acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D. EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>10/5/66</u>	
22. DATE SIGNED			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-7-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MT. HEBRON Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>FRUSHING, L.I., N.Y.</u>
24. FUNERAL DIRECTOR <u>CONDORCE FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>42179th St. N.W.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 7 1966</u>	

11310

11310

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14347

CERTIFICATE OF DEATH

14347

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence, before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>1123 Quebec St</u>	
3. NAME OF DECEASED (Type or print) First <u>Celia</u> Middle <u>Ferber</u> Last <u></u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>31</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/26/84</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR: Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown - Goldman</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Hosp Records</u>		Address <u></u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Coronary failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>AS HD</u> (b) <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>bronchopneumonia, diabetes</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> , 19 <u>66</u> , to <u>10/31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>66</u> and that death occurred at <u>9:14</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Jay R Shapiro</u>		22b. DATE SIGNED <u>10/31/66</u>		22c. PHYSICIAN'S NAME (Type) <u>JAY R SHAPIRO</u>	
22d. ADDRESS <u>8218 Wisconsin Ave - Beth, Md</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
23b. DATE THEREOF <u>11-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIVERSIDE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>ROCHELLE PARK - N. J.</u>	
24. FUNERAL DIRECTOR <u>B Langansky + Son</u>		ADDRESS <u>3501 - 4th St</u>		25a. REC'D BY REGISTRAR <u>Nov 3 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>Nov 3 1966</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11541

11541

RECEIVED
FEB 11 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14348

CERTIFICATE OF DEATH

14348

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>2 Wks</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>9037 Manchester Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Amelia</u> First <u>Fischer</u> Middle <u>Frederick</u> Last		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 22, 1895</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME (Unknown) <u>O'Halloran</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>220-48-7568</u>	
17. INFORMANT <u>Mr. G. Frederick Speckel</u>		Address <u>9037 Manchester Rd. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arterial thrombosis</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>congestive heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>1-2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from <u>1963</u> , 19 <u>66</u> , to <u>6 Oct</u> , 19 <u>66</u> , that (II) (we) last saw the deceased alive on <u>6 Oct</u> , 19 <u>66</u> , and that death occurred at <u>11:55 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ernest E. Harmon</u> M.D.		22b. DATE SIGNED <u>6 Oct 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ernest E. Harmon MD</u>		22d. ADDRESS <u>9301 Lakeside Rd Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 10, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Kensico Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Mt. Airy, New York</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Purphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 10 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1-334

STATE OF MICHIGAN

1-334

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14349

14349

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		d. STREET ADDRESS <u>404 Greenlawn Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>HAZEN WILLIAM FLEET</u>		4. DATE OF DEATH Month <u>10</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-30-01</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumber work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wm. Frederick Fleet</u>		14. MOTHER'S MAIDEN NAME <u>Eva Bullis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>108-100176</u>	
17. INFORMANT <u>Wife - Mrs. Claire B. Fleet</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X Acute bilateral bronchopneumonia</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u> </u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Pulmonary emphysema, marked</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10 Oct 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 13 1966</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14350

14350

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY in 1b <u>35 days.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DICKERSON</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>Rt # 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>R</u> Last <u>Flood</u>				4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>1-1-01</u>		9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>16</u> Days <u>19</u> Hours <u>4</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALBY'S DELICATESSEN</u>		11. BIRTHPLACE (County & State, or foreign country) <u>PHIL, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. Flood</u>				14. MOTHER'S MAIDEN NAME <u>ANNA V. Flood</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes Army</u>		16. SOCIAL SECURITY NO. <u>197-09-70039</u>		17. INFORMANT Address <u>1619 Edgely St</u> <u>MARY Louise Kelly Flood PHIL, PA</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Venous</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Renal Failure</u> DUE TO (c) <u>Nephrosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 month</u> <u>2 years</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <u>Hypertensive Cardiovascular Disease; Pyelonephritis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. DECEASED WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/1</u> , 19 <u>66</u> , to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Macdon</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert C. Macdon</u>				22d. ADDRESS <u>809 Viers Mill Rd, Rockville</u>			
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>10/29/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes</u>		23d. LOCATION (City or Town) (County) (State) <u>Philadelphia, Pa.</u>	
24. FUNERAL DIRECTOR <u>Sam Butler Inc, Funeral Home</u> <u>3900 Georgia Ave NW, Wash. DC.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 26 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11320

RECEIVED DE DEATH

11320

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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FOR STATE
HEALTH DEPT.

14351

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14351

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 15-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Naval Hospital, Bethesda, Md.				d. STREET ADDRESS 1615 Bradley Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) N		First J		Middle FORD		Last FORD	
4. DATE OF DEATH October 9		Month October		Day 9		Year 1966	
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1916	9. AGE (In years last birthday) 50	IF UNDER 1 YEAR Months 50 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Coast Guard		10b. KIND OF BUSINESS OR INDUSTRY N/A		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 426 01 7043		17. INFORMANT P.O. Box 635, Rockville, Md. Mrs. Elizabeth S. Ford, 1615 Bradley Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap		M.D. BELDEN R. REAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED OCT. 10, 1966	
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-13-66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) _____ (County) _____ (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Robert A. Pumphrey				Address Federal Home		25a. REC'D BY REGISTRAR OCT 13 1966	
7557 Wisconsin Ave., Bethesda, Maryland				25b. REGISTRAR'S SIGNATURE Charles Judge			

1-25-51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

14352

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14352

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b. <u>3 mos. 2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Althea Woodland Nursing Home</u> <u>1000 Daleview Dr.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8505 Springvale Rd. Silver Spring</u> d. STREET ADDRESS <u>Md. 15-1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Melissa First Middle Last</u> <u>FRANCIS</u>		4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 8, 1891</u>
9. AGE (In years last birthday) <u>75 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MANAGER LAUNDRY Station</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LAUNDRY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>William Davis</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>322-32-2317</u>	
17. INFORMANT <u>Mrs. Hazel F. Mibroy</u>		Address <u>Sil. Sp. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) (County) (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>65</u> , to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>66</u> , and that death occurred at <u>9:20</u> P.M. from the causes and on the date stated above.	
22a. SIGNATURE <u>A. F. Thibadeau</u>		22b. DATE SIGNED <u>10/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A. F. THIBABEAU</u>		22d. ADDRESS <u>10111 COLESVILLE RD. SIL. SP. MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-29-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East Lawn Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>McLean County, Ill.</u>	
24. FUNERAL DIRECTOR <u>Francis J. Collins</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>3821-14th St. NW. Wash. D.C.</u>		DATE <u>OCT 28 1966</u>	

14332

14332

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14353

CERTIFICATE OF DEATH

14353

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY MD.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING, MD.</u>				c. LENGTH OF STAY IN 1b <u>6 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS Hospital</u>				d. STREET ADDRESS <u>8209 Schrider Street</u>			
3. NAME OF DECEASED (Type or print) First <u>SIGRID</u> Middle <u>C</u> Last <u>FREY</u>				4. DATE OF DEATH Month <u>OCT</u> Day <u>26</u> Year <u>1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1902</u>	
				9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>19</u> Hours <u>66</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>			
13. BIRTHPLACE (County & State, or foreign country) <u>Ronneley, XX Sweden</u>				14. CITIZEN OF WHAT COUNTRY? <u>Sweden</u>			
15. FATHER'S NAME <u>Johan Adolf Karlsson</u>				16. MOTHER'S MAIDEN NAME <u>Mathilda Johanna</u>			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				18. SOCIAL SECURITY NO. <u>None</u>			
19. INFORMANT <u>Karl Frey</u>				20. ADDRESS <u>8209 Schrider Street Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u> DUE TO <u>Chronic Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>5870</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
21. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				24. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/24</u> to <u>10/26</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> , 19 <u>66</u> , and that death occurred at <u>12:45 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>William D. Aud</u>				22b. DATE SIGNED <u>10/24/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>William D. Aud, M.D.</u>				22d. ADDRESS <u>9006 Colesville Rd., Silver Spring, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Clark & Wilson Warner E. Humphrey, Inc.</u>				25. REC'D BY REGISTRAR <u>Charles Judge</u>			
26. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>				27. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

14323

STATE OF TEXAS

14323

Silver Spring

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14354

14354

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home		d. STREET ADDRESS 3511 Sandy Court	
3. NAME OF DECEASED (Type or print) First Clara Middle ---- Last Galler		4. DATE OF DEATH Month Oct. Day 1 Year 1966	
5. SEX Female	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/81
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months ---- Days ---- Hours ---- Min. ----	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ----	
11. BIRTHPLACE (County & State, or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leon Worth		14. MOTHER'S MAIDEN NAME Rachel Lutzsky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 578-09-2425	
17. INFORMANT Isadore Galler-3511 Sandy Ct. Kens. Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Unknown			INTERVAL BETWEEN ONSET AND DEATH < 1 hr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ----	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April , 19 66 , to present , 19 66 that (I) (we) last saw the deceased alive on July 10 , 19 66 , and that death occurred at 8:30 A.M. from causes and on the date stated above.			
22a. SIGNATURE George Sharpe m.d.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) George Sharpe		22d. ADDRESS 10400 Connecticut Ave Kensington	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/3/66	23c. NAME OF CEMETERY OR CREMATORY D.C. Lodge Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR B. Banzansky Son		25a. REC'D BY REGISTRAR 3501-14 St. N.W.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 3 1966	

2001

OF DEF

2025

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14355

CERTIFICATE OF DEATH

14355

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>5420 Conn. Ave. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Rachele P. Leland</u> (First Middle Last)				4. DATE OF DEATH <u>10-14</u> 19 <u>66</u> (Month Day Year)			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 19, 1897</u> 69 yrs.	
9. AGE (In years last birthday) <u>69</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt. Emp.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>James L. Leland</u>			
14. MOTHER'S MAIDEN NAME <u>Anna Hood</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown) (If yes give war or dates of service) <u>Yes W.W.I.</u>			
16. SOCIAL SECURITY NO. <u>W.W.I.</u>				17. INFORMANT <u>Mrs. Huff-nice</u> Address <u>10114 Ashland Dr. Kensington, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular hemorrhage</u> Severe 330X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Rupture of cerebral vessel</u> DUE TO (c) <u>Arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>INTERVAL BETWEEN ONSET AND DEATH 14 hours</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>10-14</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>10-14</u> , 19 <u>66</u> , and that death occurred at <u>11:05</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Stewart Clapp M.D.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>10-14-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>				22d. ADDRESS <u>4740 Chevy Chase Dr. Chevy Chase Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-17-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> Address <u>5130 Wisc. Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR <u>Oct 19 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

25541

5264

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
14356									
1. PLACE OF DEATH									
a. COUNTY <u>Montgomery</u> MARYLAND									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN lb <u>10 hours</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>									
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>									
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>									
d. STREET ADDRESS <u>408 Calvin Lane</u>									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>Gennifer Lynn Geyer</u>									
4. DATE OF DEATH <u>October 19 1966</u>									
5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Oct. 16, 1966</u> 9. AGE (In years last birthday) <u>3</u> IF UNDER 1 YEAR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY									
11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
13. FATHER'S NAME <u>Max A. Geyer</u> 14. MOTHER'S MAIDEN NAME <u>Lucy Robinson</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <u>----</u> 17. INFORMANT <u>Max A. Geyer (Father) same item #2</u> Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>7541 Congenital heart disease with complete</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>interruption of Aortic arch, and descending</u>									
(c) <u>aorta arising from ductus arteriosus</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
22. DATE SIGNED <u>OCT. 19, 1966</u>									
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D., Rockville, Md.</u> Address (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>10/21/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u> 23d. LOCATION (City, town or county) <u>Silver Spring, Md.</u> (State)									
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u> Address <u>1331 Rockville Pike Rockville, Md.</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> DATE <u>OCT 24 1966</u>									

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1999 2000 2001 2002

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

14357

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14357

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>15810 Bradford Rd. Silver Spring</u> c. LENGTH OF STAY IN 1b <u>1 1/2 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bradford Rest Home, Silver Spring</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlottesville, Md.</u> d. STREET ADDRESS <u>1511</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ella May Gibson</u> First Middle Last		4. DATE OF DEATH Month <u>10</u> Day <u>30</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-6-87</u> 9. AGE (In years last birthday) <u>79</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Hacht</u>		14. MOTHER'S MAIDEN NAME <u>Mary Bruce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-54-8695</u>	
17. INFORMANT <u>Record - Bradford Rest Home</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-20</u> , 19 <u>65</u> , to <u>10-30</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-30</u> , 19 <u>66</u> , and that death occurred at <u>12:15 P.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Clive E. Jackson</u>		22b. DATE SIGNED <u>10-30-66</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>John Wesley Cem.</u>		23d. LOCATION (City, town or county) (State) <u>CLARKSBURG, MD.</u>	
24. FUNERAL DIRECTOR <u>George R. Snowden</u>		25a. REC'D BY REGISTRAR <u>NOV 2 1966</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1933

1933

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14358

CERTIFICATE OF DEATH

14358

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bethesda</i>		c. LENGTH OF STAY IN 1b <i>7 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i>		d. STREET ADDRESS <i>109 Beall Ave</i>	
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Samet</i> Last <i>Goldstein</i>		4. DATE OF DEATH Month <i>10</i> Day <i>31</i> Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>Can</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8/1/99</i>
9. AGE (In years last birthday) <i>67</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Baltimore Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>David Samet</i>		14. MOTHER'S MAIDEN NAME <i>?</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Bernice Grossman</i>		Address <i>Same as above</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic cardiovascular disease</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Obesity, Fatty metaporphysis Liver,</i>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>2/2</i> , 19 <i>64</i> , to <i>10/31</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>10/31</i> , 19 <i>66</i> and that death occurred at <i>4:40</i> P.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Charles Judge</i>		22b. DATE SIGNED <i>10/31/66</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>11/2/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Agudas B'nai Jacob</i>	23d. LOCATION (City or Town) (County) (State) <i>Rosedale Balto. Md.</i>
24. FUNERAL DIRECTOR <i>JACK LEWIS, INC.</i>		25a. REC'D BY REGISTRAR <i>NOV 3 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. ADDRESS <i>2100 Eutaw Place Balto. Md.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14324

14325

14324 14325 14326 14327 14328 14329 14330 14331 14332 14333 14334 14335 14336 14337 14338 14339 14340 14341 14342 14343 14344 14345 14346 14347 14348 14349 14350 14351 14352 14353 14354 14355 14356 14357 14358 14359 14360 14361 14362 14363 14364 14365 14366 14367 14368 14369 14370 14371 14372 14373 14374 14375 14376 14377 14378 14379 14380 14381 14382 14383 14384 14385 14386 14387 14388 14389 14390 14391 14392 14393 14394 14395 14396 14397 14398 14399 14400

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14359

CERTIFICATE OF DEATH

14359

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 1511	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>108 Williamsburg</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Green</u>		4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/4/66</u>
9. AGE (In years lost birthday) <u>4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles S. Green</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Dauphinais</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Father</u>		Address <u>—</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO (b) <u>Pulmonary atelectasis</u> DUE TO (c) <u>Immaturity</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> , 19 <u>66</u> , to <u>10-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-4</u> 19 <u>66</u> and that death occurred at <u>4²⁰</u> A.M., from causes and on the date stated above.			
22a. SIGNATURE <u>James S. Stanton</u> M.D.		22b. DATE SIGNED <u>10/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James S. Stanton</u>		22d. ADDRESS <u>50 W. Edmonston Dr Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26. RECORD BY REGISTRAR <u>10/11/66</u>		DATE <u>OCT 11 1966</u>	

232374

14324

CERTIFICATE OF DEATH

14324

10/4/40

female white

Green

Ward (see Hospital)

Waverly, Md.

Place of Death

10/4/40

Waverly, Md.

THIS CERTIFICATE IS VALID ONLY WHEN SIGNED BY THE REGISTRAR OF DEATHS FOR THE DISTRICT OF COLUMBIA.

FOR STATE
HEALTH DEPT.

14360

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14360

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring c. LENGTH OF STAY IN lb 15-1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring Chevy Chase d. STREET ADDRESS 7203 Rollingwood Drive e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) EVERETT TEMPLE GREENSTREET				4. DATE OF DEATH Month Oct. Day 17 Year 1966			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 13, 1901	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Masonry Contractor		10b. KIND OF BUSINESS OR INDUSTRY Contracting		9. AGE (In years last birthday) 64 yrs.	
11. BIRTHPLACE (State or foreign country) Washington, D. C.				12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Temple Bird Greenstreet				14. MOTHER'S MAIDEN NAME Buelah Allen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 577-07-6216		17. INFORMANT Everett T. Greenstreet, Jr. Rd., Ch. Ch., Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Kidney peritoneal hemorrhage DUE TO (b) Ruptured aortic aneurysm DUE TO (c) Atherosclerosis of aorta Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE John G. Ball				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) John G. Ball, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/18/66			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-20-1966		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION (City or Town) (County) (State) Prince Georges Co. Md.	
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc.				25a. RECD BY REGISTRAR DATE OCT 20 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge	
5130 Wisc. Ave. N.W. Wash. D.C.							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1430

1430

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

14361

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14361

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>14 1/2</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland - Prince George</i>		b. COUNTY <i>Prince George</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Avondale</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sanitarium & Hospital</i>						d. STREET ADDRESS <i>4801 Russell Avenue</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Preston</i>			First <i>Albert</i>			Middle <i>Guy</i>			Last		
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>July 19, 1998</i>		9. AGE (In years lost, birthday) yrs. <i>68</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>P.O. Apt.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Registry in P.O.</i>		11. BIRTHPLACE (State or foreign country) <i>Wash. D.C.</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Guy</i>						14. MOTHER'S MAIDEN NAME <i>Hawkins</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. <i>- - -</i>		17. INFORMANT Address <i>Wife - Mrs. Irene - Same.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>Acute Coronary Insufficiency</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Artery Heart Disease</i> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Belden R. Read</i>				EXAMINER'S NAME (Type) <i>BELDEN R. READ, M.D.</i>				22. DATE SIGNED <i>OCT. 11, 1966</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>10-13-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Nat'l. Memorial Park</i>		23d. LOCATION (City or Town) (County) (State) <i>Falls Church, Va.</i>			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Inc.</i>						25a. REC'D BY REGISTRAR <i>OCT 13 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

MEDICAL CERTIFICATION

10541

FOR STATE HEALTH DEPT.

14362

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14362

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>15-18</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>11015 Bluebell Lane</u>		d. STREET ADDRESS <u>11015 Bluebell Lane</u>	
3. NAME OF DECEASED (Type or print) <u>DAVID</u> First Middle Last		4. DATE OF DEATH <u>10-23-66</u> Month Day Year	
5. SEX <u>M</u> 6. COLOR OR RACE <u>Cauc.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Apr. 6, 1935</u>		9. AGE (In years last birthday) <u>31</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Archivist</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>George P. Haas</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Suter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes. Korean</u>		16. SOCIAL SECURITY NO. <u>047-26-6646</u>	
17. INFORMANT <u>Wife</u> Address <u>Marian W. Haas</u> Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrathoracic Hemorrhage</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>due to gunshot wound thru</u> lost. (c) <u>heart, self inflicted.</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>deceased, depressed, shot self</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-23-66</u> o.m. a.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Kensington</u> (County) <u>Montgomery</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		22. DATE SIGNED <u>OCT. 24, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-27-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Menonite Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Millersville, Penna</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Maryland</u>	
25a. REC'D BY REGISTRAR <u>OCT 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14388

14388

Cleared & Medical Examiner RSR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14363

CERTIFICATE OF DEATH

14364

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>50 min.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colesville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hospital</u>				d. STREET ADDRESS <u>13709 Sherwood Forest Dr.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Stella</u> Middle <u>NNN</u> Last <u>Hanns</u>				4. DATE OF DEATH Month <u>10</u> - Day <u>27</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Wh.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-29-900</u>		
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min.		IF UNDER 24 HRS. Hours <u>66</u> Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswt.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Anthony Orloski</u>				14. MOTHER'S MAIDEN NAME <u>Josephine Golembiewski</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mr. Wm. F. Hanns - Son</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic coronary vascular disease</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>febr.</u> , 19 <u>50</u> , to <u>Oct 27</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 27</u> 19 <u>66</u> , and that death occurred at <u>11:00</u> M, from causes and on the date stated above.								
22a. SIGNATURE <u>Ronald S. Fleischer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-27-66</u>		
22c. PHYSICIAN'S NAME (Type) <u>RONALD S. FLEISCHER</u>				22d. ADDRESS <u>7411 RIGGS Rd HYATTSVILLE, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 29, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St Stanislaus Polish Nat</u>		23d. LOCATION (City or Town) (County) (State) <u>Scranton Pa</u>		
24. FUNERAL DIRECTOR <u>F Gasch's Sons</u>				ADDRESS <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 1966</u>		
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

4354

134

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14364 Item 1c Film 6302 11/27/66 mh 14365											
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Tennessee b. COUNTY ✓						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chattanooga 79-3						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					d. STREET ADDRESS 1106 South Moore Drive						
3. NAME OF DECEASED (Type or print) First Claude Middle Emmitt Last Hardeman					4. DATE OF DEATH Month October Day 26 Year 1966						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 28 Sept. 1903		9. AGE (in years last birthday) 63 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Industrial Machine Co.		11. BIRTHPLACE (County & State, or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		6. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13. FATHER'S NAME Marion Hardeman					14. MOTHER'S MAIDEN NAME Loraine Brock						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 417-09-6795		17. INFORMANT The Medical Record, The Clinical Center, Bethesda, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pseudomonas Septicemia 2043 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Hepatic Failure (c) Acute Myelogenous Leukemia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Renal Failure										INTERVAL BETWEEN ONSET AND DEATH 48 hours 3 weeks 7 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that ✓ (this hospital) attended the deceased from 20 April , 19 66 , to 26 Oct. , 19 66 , that (X) (we) last saw the deceased alive on 26 October 19 66 , and that death occurred at 7:55 , from the causes and on the date stated above.											
22a. SIGNATURE Paul Neiman					ATTENDING PHYS. <input type="checkbox"/> A.M. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 26 October 1966				
22c. PHYSICIAN'S NAME (Type) Paul Neiman, M.D.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-transit 10-28-66			23b. DATE THEREOF 10-28-66		23c. NAME OF CEMETERY OR CREMATORY Lake View Cem.		23d. LOCATION (City, town or county) (State) Chattanooga, Tenn.				
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR NOV 1 1966		25b. REGISTRAR'S SIGNATURE Charles Judge				

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14365

14366

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>			c. LENGTH OF STAY IN, lb <u>2 1/2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>77 Froude Circle</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KATHRYN</u> Middle <u>F.</u> Last <u>HARDY</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>25</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan - 29 - 1905</u>		9. AGE (In years last birthday) yrs. <u>61</u>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NAT INST HEALTH</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Fitzpatrick</u>				14. MOTHER'S MAIDEN NAME <u>Alice O'Connor</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-20-8113</u>		17. INFORMANT <u>Charles Schlichter</u> Address <u>Same as Item 2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>445X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant hypertension</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1-2 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9/30</u> , 19 <u>64</u> to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> A.M. from causes and on the date stated above.							
22a. SIGNATURE <u>I. L. Marks</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>I. L. MARKS, M.D.</u>				22d. ADDRESS <u>320 University Blvd. E. Sec 4</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>10-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Agnes Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Menands, New York</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 31 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Thereafter, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2084

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14366

CERTIFICATE OF DEATH

14363

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>4 DAYS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>		d. STREET ADDRESS <u>527 DALE DRIVE APT #</u>	
3. NAME OF DECEASED (Type or print) First <u>CARL</u> Middle <u>A</u> Last <u>HARMON</u>		DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/14/00</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BACK CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Banking</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Monroeville D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Ida A Harmon</u>		14. MOTHER'S MAIDEN NAME <u>Ida Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-12 7702</u>	
17. INFORMANT <u>Bernice Harmon</u>		Address <u>3406 Pot NW</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic Ca (R) lung with metastasis to thyroid gland. pros brain.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Myocardial infarction pros central embolism.</u> DUE TO (c) <u>cardiome. accident sec to a) & b)</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>28 Sept., 1966</u> , to <u>28 Oct., 1966</u> , that (I) (we) last saw the deceased alive on <u>28 Oct., 1966</u> , and that death occurred at <u>5:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>V de Guzman</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Vicente C. de Guzman MD</u>		22d. ADDRESS <u>1234 19th N.W. Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 31 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County Md</u>	
24. FUNERAL DIRECTOR <u>Dr. Del Funeral Home Wash DC</u>		25. REC'D BY REGISTRAR DATE <u>NOV 4 1966</u>	
26. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		27. REGISTRAR'S SIGNATURE	

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OFFICE OF THE SECRETARY OF THE NAVY
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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14367

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

14367

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda c. LENGTH OF STAY IN ID 14 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 47.3 d. STREET ADDRESS 800 Bellevue Street, S.E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Elizabeth Last Henderson		4. DATE OF DEATH Month October Day 5 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 16 June 1936
9. AGE (In years last birthday) 30 yrs.		IF UNDER 1 YEAR Months 0 Days 0 IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) District of Columbia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bert Akins		14. MOTHER'S MAIDEN NAME Lois Toles	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-48-0340	
17. INFORMANT The Medical Records		Address The Clinical Center, Bethesda, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Renal Failure 2041 transformation with Renal Infiltration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Granulocytic Leukemia in Blastic / 8 Days DUE TO (c) Chronic Granulocytic Leukemia 2 Years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept. 21 , 19 66 , to Oct. 5 , 19 66 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 5 , 19 66 , and that death occurred at 3:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE Paul E. Neiman MD		22b. DATE SIGNED 6 October 1966	
22c. PHYSICIAN'S NAME (Type) Paul E. Neiman, MD.		22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-11-66	
23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cemetery		23d. LOCATION (City, town or county) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Crouch's Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 18 1966	

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Office of the Surgeon General

300 Bellevue Street, S.E.

Washington, D.C.

10 June 1936

Office of the Surgeon General

USA

John J. ...

The Medical Board

The Clinical Center, National

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10 June 1936

10 June 1936

10 June 1936

The Clinical Center, National

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14368

CERTIFICATE OF DEATH

14368

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 10 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN		d. STREET ADDRESS 6312 WILSON LANE	
3. NAME OF DECEASED (Type or print) RAQUEL M. HERNANDEZ		4. DATE OF DEATH OCT. 25 19 61	
5. SEX FEMALE	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/16
9. AGE (In years last birthday) 50		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CAMAGÜEY, CUBA		12. CITIZEN OF WHAT COUNTRY? CUBA	
13. FATHER'S NAME ERNESTO CUESTA		14. MOTHER'S MAIDEN NAME RUFINA ZALDIVAR	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 266-32-7142	
17. INFORMANT Ernesto Cuesta		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Melanotic Carcinoma to brain DUE TO 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma originating in pelvis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/16/1961 to 10/25/1961 , that (I) (we) last saw the deceased alive on 10/24/1961 , and that death occurred at 11:34 M, from causes and on the date stated above.			
22a. SIGNATURE Robert C. Macon		22b. DATE SIGNED 10/25/66	
22c. PHYSICIAN'S NAME (Type) ROBERT C. MACON		22d. ADDRESS 809 Viers Mill Rd. Rockville	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-27-66	
23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION (City or Town) (County) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 31 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #21 Film #3182 10/26/66 pc

14369

CERTIFICATE OF DEATH

14369

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN lb 1 year	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville 15-1		d. STREET ADDRESS 1015 DeBeck Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1015 DeBeck Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First LAWRENCE Middle A. Last HIGGINS		4. DATE OF DEATH Month October Day 5 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 26, 1899
9. AGE (In years last birthday) 67 yrs.		10. IF UNDER 1 YEAR Months 6 Days 9 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Surveyor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Rockville, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank H. Higgins		14. MOTHER'S MAIDEN NAME Roberta Baker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-20-1084	
17. INFORMANT Nephew		Address 6 Maryland Ave Franklin H. Wilson, Gaithersburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SEVERE GENERALIZED ARTERIOSCLEROSIS DUE TO 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) MI DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 8 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/15/66 , to 10/15/66 , that (I) (we) last saw the deceased alive on 10/14/66 9/27/66 , and that death occurred at 6:15 AM , from causes and on the date stated above.			
22a. SIGNATURE W. G. Hall M.D.		22b. DATE SIGNED 10/15/66	
22c. PHYSICIAN'S NAME (Type) W. G. HALL		22d. ADDRESS 615 W. Montgomery Ave. Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-7-66	
23c. NAME OF CEMETERY OR CREMATORY Rockville Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 7 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.



14370

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14370

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney			c. LENGTH OF STAY IN 1b 22 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Damascus		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 26510 Ridge Rd.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ray Middle NNN Last Hilton				4. DATE OF DEATH Month 10 Day 23 Year 19 66			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/22/93	
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME McClemen Hilton				14. MOTHER'S MAIDEN NAME Catherine Molesworth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-36-8053		17. INFORMANT Address Hospital Records, Olney, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Acute bilateral bronchopneumonia DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Read M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Oct. 23, 1966					
EXAMINER'S NAME (Type) BELDEN R. READ M.D.		Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1966		23c. NAME OF CEMETERY OR CREMATORY Montgomery Meth.		23d. LOCATION (City or Town) (County) (State) Clagettville, Md.	
24. FUNERAL DIRECTOR ADDRESS Olin L. Molesworth, Damascus, Md.				25a. REC'D BY REGISTRAR DATE OCT 28 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14371					14371				
Item #2b, c, & d Film #8381 10/21/66									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1000 Silver Spring</u> Wash, D.C. <u>47-3</u>				
c. LENGTH OF STAY IN 1b <u>4 yrs.</u>					d. STREET ADDRESS <u>3801 Connecticut Ave.</u> e. IS RESIDENCE ON A FARM? <u>1000 Dalefield Dr</u> N.W. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Althea Woodland Nursing Home</u>									
3. NAME OF DECEASED (Type or print) <u>Anna Lundy Holbrook</u>					4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 29, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) <u>Troy, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u> Hours <u></u> Min. <u></u>	
13. FATHER'S NAME <u>Henry Schoefield</u>					14. MOTHER'S MAIDEN NAME <u>Leitita Lundy</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>8112 Carroll Lane, Silver Spring, Maryland</u> <u>Mrs. Mary L. Kelly-Daughter-</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> 331X DUE TO (b) <u>Multiple Cerebral Vascular accidents</u> DUE TO (c) <u>Arteriosclerosis and hypertension</u> CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Aphasia and mild right hemiplegia June 1962</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1953</u> to <u>Oct 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>Sept 14, 1966</u> , and that death occurred at <u>7a</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Stewart Clapp</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>10.4.66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stewart Clapp M.D.</u>					22d. ADDRESS <u>4740 Chevy Chase Dr. Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>			23b. DATE THEREOF <u>10-5-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>			23d. LOCATION (City, town or county) (State) <u>Suitland, Maryland</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>					ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

14371

14371

Robert A. Thompson, Bethesda, Maryland

10-3-56

10-3-56

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14372

CERTIFICATE OF DEATH

14372

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>ANNAPOLIS</u>	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN lb <u>6 days.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITORIUM</u>		d. STREET ADDRESS <u>54 WILSON ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>COLLINS</u> First Middle Last <u>HOLCOMB</u>		4. DATE OF DEATH Month <u>OCT</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>MAR. 23 1880</u> 86 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED RETAILING BUS</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>MICHIGAN</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>COLLINS HOLCOMB SR.</u>		14. MOTHER'S MAIDEN NAME <u>MARIA HUNTOON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>SPANISH AMERICAN</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. E.E. CHRISTENSEN</u>		Address <u>54 Wilson Rd. ANNAPOLIS MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.0</u> IMMEDIATE CAUSE (a) <u>ASHD c Heart Block</u> DUE TO (b) <u>2 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN DEATH AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> , 19 <u>66</u> , to <u>10-10</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10-10</u> 19 <u>66</u> , and that death occurred on <u>10-10</u> 19 <u>66</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>D. P. Sengstack M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-10-66</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-12-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON, VA</u>
24. FUNERAL DIRECTOR <u>LIVES FUNERAL HOME</u> ADDRESS <u>2847 Wilson Blvd. ARLINGTON, VIRGINIA</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 13 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1554

Test

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14373

14373

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>5009 MALDEN DR.</u>			
3. NAME OF DECEASED (Type or print) <u>Marie G. Holinger</u>				4. DATE OF DEATH <u>Oct. 10, 1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 16, 1906</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>Wash - D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward R. Greer</u>				14. MOTHER'S MAIDEN NAME <u>Marie -</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT <u>Emil H. Holinger - See Item #2.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Metastatic</u> <u>144X</u> DUE TO (b) <u>Carcinomatosis</u> DUE TO (c) <u>Cancer of Mouth</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>Oct. 10, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-13-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
5130 Wisc. Ave. N.W. Wash. DC.				DATE <u>OCT 13 1966</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14374

14374

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md. c. LENGTH OF STAY IN b 5 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Gaithersburg d. STREET ADDRESS 311 South Frederick e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Anna T. Hollander First Middle Last				4. DATE OF DEATH October 11 1966 Month Day Year					
5. SEX F		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-24-33 1874		9. AGE (In years last birthday) 91 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H. Wife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Jefferson Co., Iowa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Jacobson				14. MOTHER'S MAIDEN NAME Christina Louisa					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Bernice Foster		Address Same as 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED ARTERIOSCLEROSIS DUE TO (b) 4201 ESSENTIAL HYPERTENSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) CORONARY THROMBOSIS								INTERVAL BETWEEN ONSET AND DEATH 30 YEARS 30 YEARS 30 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC RENAL FAILURE CONGESTIVE HEART FAILURE								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MARCH 25, 1966 , to OCTOBER 12, 1966 , that (I) (not) last saw the deceased alive on OCTOBER 6, 1966 , and that death occurred at 8 A M, from the causes and on the date stated above.									
22a. SIGNATURE Gordon S. Rosenberger M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED OCT 11, 1966			
22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger				22d. ADDRESS 310 WEST MONTGOMERY AVE. ROCKVILLE, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 10-11-66		23c. NAME OF CEMETERY OR CREMATORY New Sweden Cemetery		23d. LOCATION (City, town or county) Jefferson County, Fairfield (State) Iowa			
24 FUNERAL DIRECTOR'S SIGNATURE Francis H. Barber				ADDRESS Laytonsville, Md.		25a. REC'D BY REGISTRAR OCT 14 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

14375

CERTIFICATE OF DEATH

Reg. Dist. No.

14375

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda 1571	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 9716 Parkwood Drive		d. STREET ADDRESS 9716 Parkwood Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First KATHARINE Middle L. Last HOLLISTER		4. DATE OF DEATH Month Oct. Day 3, Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 7, 1895
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 9 Days 8	
11. IF UNDER 24 HRS. Hours 9 Min. 8			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harry Lawder		14. MOTHER'S MAIDEN NAME Dora Crampton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Husband		Address Same as Item 2.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Cerebral Vascular accidents DUE TO 2901 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subacute combined degeneration of cord DUE TO Spinal (c) Cause undetermined		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 5 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL-EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19 50 , to Oct 3 , 19 66 , that I last saw the deceased alive on Oct 3 , 19 66 , and that death occurred at 6:45 p M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Stewart Clapp		ADDRESS (Street, city or town, state) DATE SIGNED 4740 Chevy Chase Dr 10-3-66	
PHYSICIAN'S NAME (Type) Stewart Clapp MD		Chevy Chase Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit	22b. DATE THEREOF 10/7/1966	22c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery	22d. LOCATION (City, town, or county) (State) Troy New York
23. FUNERAL DIRECTOR'S SIGNATURE Robert A. Pumphrey		ADDRESS Bethesda, Maryland	
24a. REC'D BY REGISTRAR DATE OCT 7 1966		24b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2564

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14376

14376

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY in 1b <u>26 hrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>916 View mill Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth L. Holt</u>				4. DATE OF DEATH <u>Oct 15 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/23/09</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gov. work</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Eugene L. Bostaux</u>		14. MOTHER'S MAIDEN NAME <u>Mary Becker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>5 77-10-4234</u>		17. INFORMANT <u>Walter T. Holt, Jr. 7 term #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the breast, with metastasis.</u> DUE TO <u>metastasis.</u> Conditions, if any, which gave rise to immediate cause (b) <u>170X</u> (c) <u>(Right radical mastectomy March 1965)</u> DUE TO <u>metastasis.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>				INTERVAL BETWEEN ONSET AND DEATH <u>about 2 years.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1959</u> to <u>Oct 15</u> , 19 <u>66</u> , that (I) <u>was</u> last saw the deceased alive on <u>Oct 14</u> , 19 <u>66</u> , and that death occurred <u>8:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. A. Linthicum</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-17-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. A. Linthicum</u>				22d. ADDRESS <u>110 S. Washington St. Rockville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>		23d. LOCATION (City, town or county) (State) <u>Rockville Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				ADDRESS <u>1331 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 18 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14375

14375

REVENUE OF TEXAS

State of Texas, County of Rockwall, 10/10/00, Parkman

Yoon, Charles General Home 1771 Rockville, aka
Rockville, Mo.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

14377

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14377

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN TB 5 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital				d. STREET ADDRESS 14632 Peach Orchard Road			
3. NAME OF DECEASED (Type or print) First Hans Middle E. Last Hoppensack				4. DATE OF DEATH Month October Day 31 , Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/30/89	9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant			10b. KIND OF BUSINESS OR INDUSTRY German Govt.		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany
13. FATHER'S NAME Otto Hoppensack				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-48-9698		17. INFORMANT Mrs. Martha Hoppensack			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute intracranial hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Read		EXAMINER'S NAME (Type) BELDEN R. READ, M.D.		22. DATE SIGNED 10/31/1966		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 3, 1966		23c. NAME OF CEMETERY OR CREMATORY Burtonsville Union Cemetery		23d. LOCATION (City or Town) (County) (State) Burtonsville, Maryland	
24. FUNERAL DIRECTOR John B. Thomas Warner E. Humphrey, Inc.				25a. REC'D BY REGISTRAR NOV 4 1966		25b. REGISTRAR'S SIGNATURE f Charles Judge	

14371

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14378

Item 21 Film 6382 11/7/66 mh

CERTIFICATE OF DEATH

14378

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 3 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE		1571	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 10201 GROSVENOR PLACE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Budhi Middle Howard Last HUBBELL		4. DATE OF DEATH Month October Day 8 Year 19 66	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1912
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Floesville, Texas		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Louis Howard		14. MOTHER'S MAIDEN NAME Mattie Virginia Gray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 557-05-8082	
17. INFORMANT Charles W. Hubbell		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CARCINOMA WITH METASTASE TO MEDIASTINUM DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) AND SKULL DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 OCT , 19 66 , to 8 OCT , 19 66 , that (I) (we) last saw the deceased alive on 8 OCT 1966, and that death occurred at 7:40AM from causes and on the date stated above.			
22a. SIGNATURE M.G. Andersen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) M.G. ANDERSEN, CDR, MC, USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-12-66	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR R.A. Pumphrey, 7557 Wisconsin Ave., Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 11 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

150

02358

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

68
Cleared with medical examiner

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14379					14379				
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring			c. LENGTH OF STAY IN 1b 9 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Holy Cross Hospital					d. STREET ADDRESS 12305 Tretoria Drive			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First David		Middle A.		Last Hughes		4. DATE OF DEATH Month October Day 25 Year 19 66	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13, 1955		9. AGE (In years last birthday) 11 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard F. Hughes					14. MOTHER'S MAIDEN NAME Elizabeth Wirth				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Hospital records Address Silver Springs, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral degeneration 2890 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hurker's Syndrome DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1959 , 19 66 , to 10/30 , 19 66 , that (I) (we) last saw the deceased alive on 10/27/66 , and that death occurred at 2:00 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Murray Paul					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/25/66		
22c. PHYSICIAN'S NAME (Type) MURRAY PAUL					22d. ADDRESS Silver Springs, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/28/66		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Va		
24. FUNERAL DIRECTOR, F. Krosche sons Hyattsville Md					25a. REC'D BY REGISTRAR DATE OCT 27 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		

1437

1437

Montgomery

Maryland

Montgomery

Silver Spring

2 hours

Silver Spring

Holy Cross Hospital

12305 Arctura Drive

David

A.

Hughes

October 25,

66

Male

White

Sept. 13, 1955

11

Child

Washington, D.C.

U.S.A.

Richard E. Hughes

Montgomery

hospital records Silver Spring, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14380 CERTIFICATE OF DEATH 14380

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Md. 20014</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>114 Varnum Street, N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Patrick Kevin Hughes</u>		4. DATE OF DEATH <u>October 26 19 66</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>6 November 1956</u> 9. AGE (in years last birthday) <u>9</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Patrick E. Hughes</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Edwards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>---</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u> <u>2590</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Dehydration</u> DUE TO (c) <u>Hurler's Syndrome</u>				INTERVAL BETWEEN ONSET AND DEATH <u>24 Hours</u> <u>24 Hours</u> <u>9 1/2 Years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 26, 19 66</u> , to <u>October 26, 19 66</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>October 26, 19 66</u> , and that death occurred at <u>1130M</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph H. Zelson</u> M.O. <u>P</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>27 October 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Joseph H. Zelson, MD</u>		22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 31, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>			
23d. LOCATION (City, town or county) <u>Arlington</u>		(State) <u>Virginia</u>		23e. REC'D BY REGISTRAR <u>Charles Judge</u>			
24. FUNERAL DIRECTOR <u>John H. Walters</u>		ADDRESS <u>254 Carroll St NW Wash DC</u>		25a. DATE <u>OCT 31 1966</u>			

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Director of Columbia

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14381

14381

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE 12701 Springtree Drive Silver Spring, Md. Montgomery Cy.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring, Maryland		c. LENGTH OF STAY IN 1b 4 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Colonial Villa, Silver Spring, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle SHANNON Last Humphrey		4. DATE OF DEATH Month 10 Day 2 Year 19 66	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-13-49
9. AGE (In years lost birthday) 16 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student	
11. BIRTHPLACE (County & State, or foreign country) Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? American	
13. FATHER'S NAME James I. Humphrey, Sr.		14. MOTHER'S MAIDEN NAME Hyman, Ann Mary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT James I. Humphrey Sr.		Address Same as #2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of testicle (Mixed Teratoma) 178X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from May , 1966, to 10/2 , 1966, that (I) (we) last saw the deceased alive on 10/2 , 1966, and that death occurred at 11:45 A.M., from causes and on the date stated above.			
22a. SIGNATURE G. Leonard Gold		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/2/66
22c. PHYSICIAN'S NAME (Type) G. Leonard Gold		22d. ADDRESS 8641 Colesville Rd, Sil. Spring, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10/5/1966	23c. NAME OF CEMETERY OR CREMATORY GATE OF HEBRON Cem	23d. LOCATION (City or Town) (County) (State) SILVER SPRING, MONTGOMERY, MD
24. FUNERAL DIRECTOR W. W. CHAMBERS, Inc SILVER SPRING, MD		25a. REC'D BY REGISTRAR OCT 5 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1324

18226

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Items #2c & d Film #G381 10/10/66 pc

14382

CERTIFICATE OF DEATH

14382

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney				c. LENGTH OF STAY IN lb 238 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 901 Abcola Ave.			
3. NAME OF DECEASED (Type or print) Elizabeth Louise Hutton				4. DATE OF DEATH Month October Day 1 Year 1966			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/16/1875	
9. AGE (In years last birthday) 91 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Teacher		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William B. Miller				14. MOTHER'S MAIDEN NAME Elizah Hopkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. -		17. INFORMANT Mr. Josiah Hutton Brookeville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 6 days. years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 1947 to Oct 1 , 19 66 , that (I) (we) last saw the deceased alive on 9/30 , 19 66 , and that death occurred on 9/15 M, from causes and on the date stated above.			
22a. SIGNATURE Richard A. Yates				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-1-66	
22c. PHYSICIAN'S NAME (Type) Richard A. Yates				22d. ADDRESS Olney, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-3-66		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION (City or Town) (County) (State) Olney, Maryland	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.				25a. REC'D BY REGISTRAR DATE OCT 5 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

14388

14388

Mr. Joseph Hutton, Brookville, Mo.

Olney, Mo.

Richard A. Laine

Olney, Mo.

St. Louis

10-3-06

trial

Francis H. Butler, Brookville, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14383

Item #7 Film 72-10-23/66

CERTIFICATE OF DEATH

14383

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>15-1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradford Rest Home</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bradford Rest Home</u>		d. STREET ADDRESS <u>21, Silver Spring</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Henry Jackson</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-25-98</u> <u>68</u> yrs.
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Carroll, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-30-3639</u>	
17. INFORMANT <u>Record Bradford Nursing Home</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u>Atherosclerotic C.U. Dis.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-25</u> , 19 <u>66</u> to <u>10-3</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10-3</u> , 19 <u>66</u> and that death occurred at <u>9A</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Clive E. Jackson</u>		22b. DATE SIGNED <u>10-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>202 Martin L. Rockville, Md</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-8-66</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Friendship Church.,</u>		23d. LOCATION (City, town or county) (State) <u>Damascus, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>OCT 11 1966</u>			

1938

1938

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "January", "February", "March", "April", "May", "June", "July", "August", "September", "October", "November", "December" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14384

CERTIFICATE OF DEATH

14384

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laytonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DeBachan</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Henry</u> Middle <u>Jackson</u> Last		4. DATE OF DEATH <u>Oct 6</u> 19 <u>66</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col-</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/5/1913</u> 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Team Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Jackson</u>		14. MOTHER'S MAIDEN NAME <u>Mary DeMan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Sister Mildred Butler</u> Address <u>Same as above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of esophagus with</u> <u>150X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized metastasis and</u> DUE TO (c) <u>Marked Cachexia</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 19 66</u> to <u>Oct 5</u> , 19 <u>66</u> (I) (we) last saw the deceased alive on <u>Oct 5</u> 19 <u>66</u> and that death occurred at <u> </u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>V.C. DeGuzman, MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 6, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>VICENTE C. DE GUZMAN MD</u>		22d. ADDRESS <u>1234 19th NW. Wash D.C.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10-10-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Brookes Grove Church</u>	23d. LOCATION (City or Town) (County) (State) <u>Laytonsville, Md.</u>
24. FUNERAL DIRECTOR <u>Robert L. Surdless</u>		ADDRESS <u>Rockville, Md.</u>	25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12811

MINISTRE DE LA JUSTICE

12811

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14385

CERTIFICATE OF DEATH

14385

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>5 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel</u>			d. STREET ADDRESS <u>9299 Sudlersville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel Elizabeth Jackson</u>				4. DATE OF DEATH Month Day Year <u>Oct. 16 1966</u>			
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/13/01</u>	9. AGE (In years last birthday) <u>65</u> YRS.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Edward Jackson</u>				14. MOTHER'S MAIDEN NAME <u>Anna Lawson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes (no) or unknown) <u>No</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>W.S. & H</u> <u>Hospital Records</u>		Address <u>Takoma Park Md</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1992 Diffuse Carcinomatous</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Congestive Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office-bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>9/11</u> , 19 <u>66</u> , to <u>10/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>66</u> , and that death occurred at <u>8:15 A.M.</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Russell C. Bufalino</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct 15, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell C. Bufalino, M.D.</u>				22d. ADDRESS <u>1429 University Blvd. W. St. Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct 18, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Lawrence Hill Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>McKeesport Fayette Co. Pa</u>		
24. FUNERAL DIRECTOR <u>Arthur Walter</u>				ADDRESS <u>254 Carroll St N.W.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 18 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14335

REPORT OF DEATH

14335

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Time of Death		Signature of Physician	
Signature of Informant		Signature of Registrar	
Date of Report		Place of Report	

DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
STATE OF NEW YORK
ALBANY, N. Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14386

CERTIFICATE OF DEATH

14386

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenbelt</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp. of Silver Spring</u>		d. STREET ADDRESS <u>850501 Glendale Rd</u>	
3. NAME OF DECEASED (Type or print) <u>Matthew Joseph John</u>		4. DATE OF DEATH Month <u>October</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 10, 1966</u>
9. AGE (In years lost birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>14</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>	
13. FATHER'S NAME <u>Joseph Ross John</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Ann Lipps</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Joseph Ross John</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intrauterine hemorrhage</u> <u>7600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>in a newborn infant</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct. 10</u> , 19 <u>66</u> , to <u>Oct. 12</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct. 12</u> , 19 <u>66</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Frank Neuberger</u>		22b. DATE SIGNED <u>Oct. 12, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK Neuberger</u>		22d. ADDRESS <u>1110 Spring Street, Silver Spring</u>	
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/17/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. SIGNED BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1331 Rockville Road, Rockville, Md.</u>		DATE <u>OCT 18 1966</u>	

14386

RECORD OF DEATH

14386

Name of deceased		Date of birth	
John Doe		Jan 1, 1900	
Place of birth		Date of death	
New York City		Jan 1, 1950	
Cause of death		Place of death	
Heart disease		New York City	
Occupation		Date of burial	
Teacher		Jan 5, 1950	
Burial place		Date of interment	
Cemetery		Jan 10, 1950	
Name of informant		Signature of informant	
John Doe		[Signature]	

RECORD OF DEATH

14386

John Doe

Jan 1, 1900

Jan 1, 1950

Heart disease

New York City

Teacher

Jan 5, 1950

Cemetery

Jan 10, 1950

John Doe

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14387

CERTIFICATE OF DEATH

14387

Item #1d Film #1382 10/20/66 pc

1. PLACE OF DEATH a. COUNTY Montgomery				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 5 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11912 New Hampshire Ave.				d. STREET ADDRESS 11912 New Hampshire Ave.			
3. NAME OF DECEASED (Type or print) Edgar Firstrenton Middle Johnson Last				4. DATE OF DEATH Month Oct. Day 13 Year 1966			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1894	
9. AGE (In years last birthday) 72 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (County & State, or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME James E. Johnson			
14. MOTHER'S MAIDEN NAME Martha E. Lucas				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO. 212-14-5308				17. INFORMANT Helen Doheny Silver Spring, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized atherosclerotic cardiovascular disease. DUE TO (c) —							INTERVAL BETWEEN ONSET AND DEATH 24-48 hrs 2-3 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized atherosclerosis, Prostatic hypertrophy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1960 to 13 Oct , 1966, that (I) (we) last saw the deceased alive on 13 Oct , 1966, and that death occurred at 11 A M, from the causes and on the date stated above.							
22a. SIGNATURE Ernest E. Harmon				22b. DATE SIGNED Oct. 13, 1966			
22c. PHYSICIAN'S NAME (Type) Ernest E. Harmon				22d. ADDRESS 9301 Colesville Road Silver Spring, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-17-66		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel		23d. LOCATION (City, town or county) (State) Sunshine, Md.	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md.				25a. REC'D BY REGISTRAR OCT 18 1966			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

1438

1438

Montgomery
Silver Spring

Montgomery
Silver Spring

Robert Trenton Johnson

1912 New Hampshire Ave.

Oct. 13 66

April 8, 1961 75

Construction Co. USA

James E. Johnson

Martha E. Lucas

212-11-2308 Helen Doherty Silver Spring, Md.

Ernest E. Harmon

9301 Colasville Road

Oct. 13, 1966
Silver Spring, Md.

10-17-66 Mt. Carmel

200000, Md.

Francis M. Barber Laytonsville, Md.

Oct. 13, 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14388					14388				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Montgomery MARYLAND					Pennsylvania				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda					c. LENGTH OF STAY IN lb 24 days				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) The Clinical Center, Bethesda, Maryland					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chambersburg				
					d. STREET ADDRESS 120 Ramsey Avenue				
3. NAME OF DECEASED (Type or print) First Middle Last Ira Samuel Johnson					4. DATE OF DEATH Month Day Year October 22 1966				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 27 December 1928		9. AGE (In years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 37 yrs. 9 Months 25 Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Draftsman					10b. KIND OF BUSINESS OR INDUSTRY Engineering				
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Clarence Johnson					14. MOTHER'S MAIDEN NAME Helen Wiser				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1950-1952					16. SOCIAL SECURITY NO. 162-22-6305				
17. INFORMANT The Medical Records The Clinical Center, Bethesda, Maryland					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive Esophageal Hemorrhage 1909 DUE TO Esophagus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic malignant Melanoma invading/ DUE TO (c) Primary Malignant Melanoma of skin in the Thorax INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 Months 3 Years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Thrombocytopenia									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 28 Sept., 1966, to 22 Oct., 1966, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 22 Oct., 1966, and that death occurred at 7:55 P.M., from the causes and on the date stated above.									
22a. SIGNATURE Leroy Fass					22b. DATE SIGNED P.M. 10/23/66				
22c. PHYSICIAN'S NAME (Type) Leroy Fass, MD.					22d. ADDRESS The Clinical Center, National Institutes of Health, Bethesda, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF 10/26/66		23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial		23d. LOCATION (City, town or county) (State) Chambersburg Pa.		
24. FUNERAL DIRECTOR Robert A. Pumphrey F.H. 7557 Wisc. Ave Bethesda, Md.					25a. REC'D BY REGISTRAR DATE OCT 25 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

1438

LETTERHEAD OF HEALTH

1438

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Cleared with medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14389

CERTIFICATE OF DEATH

14389

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spring		c. LENGTH OF STAY IN 1b 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 12825 Epping Terr.	
3. NAME OF DECEASED (Type or print) Myrtle Mae Johnson		4. DATE OF DEATH Month Oct Day 23 Year 1966	
5. SEX F	6. COLOR OR RACE Cau	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/20 10/20/1900 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME Morey (Unknown)		14. MOTHER'S MAIDEN NAME (Unknown)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Son		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive heart failure DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH 30 min 1 week 15 yrs +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from April, 1966, to Oct 23, 1966, that (1) (we) last saw the deceased alive on Oct 20, 1966, and that death occurred at 11:02 AM, from causes and on the date stated above.			
22a. SIGNATURE George Skenton		22b. DATE SIGNED 10/23/66	
22c. PHYSICIAN'S NAME (Type) GEORGE SKENTON		22d. ADDRESS 10829 Georgia Avenue, Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-66	
23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Robert A. Humphrey		25a. REC'D BY REGISTRAR DATE Oct 24, 1966	
25b. REGISTRAR'S SIGNATURE John Charles Judge		25c. REGISTRAR'S SIGNATURE OCT 26 1966	

9251

1232

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

14390

14390

1. PLACE OF DEATH a. COUNTY <u>Mont.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7045-Wilson Lane</u>		d. STREET ADDRESS <u>7045 Wilson Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Anna Margaret Kart</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/30/99</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction, recent and remote</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Years.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>John G. Ball, 7936 Old Georgetown Road, Bethesda, Maryland</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or town) (County) (State) <u>Prince George Co Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
26. REC'D BY REGISTRAR <u>NOV 2 1966</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14391

14391

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>Thru 40 min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		d. STREET ADDRESS <u>9506 Baltimore Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Eckles</u> Last <u>Kay</u>		4. DATE OF DEATH Month <u>10</u> Day <u>15</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-10-82</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Builder - Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Alexander Kay</u>		14. MOTHER'S MAIDEN NAME <u>Mary Kay</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>577-10-7882A</u>	
17. INFORMANT <u>Evelyn Eckles</u> Address <u>10016 Dallas Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mammary Gland Cancer</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Stomach</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>1966</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1</u> , 19 <u>66</u> , to <u>Oct 15</u> , 19 <u>66</u> , that (I) (we) lost the deceased alive on <u>Oct 15</u> , 19 <u>66</u> , and that death occurred at <u>10:40 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W.B. Wardrop, MD</u>		22b. DATE SIGNED <u>Oct 16, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>W.B. WARDROP, MD</u>		22d. ADDRESS <u>808 Pershing Drive Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 18, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rockville Union Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas Warner & Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1994

1992

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14392

CERTIFICATE OF DEATH

14392

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>2710 JENNINGS ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH</u>		4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/15/90</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>PAUL LEAN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH DICK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>11605 Lockwood Dr SE</u>	
17. INFORMANT <u>Paul P. Kim</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>IRREVERSABLE SHOCK</u> DUE TO (b) <u>SADDLE EMBOLUS AORTIC BIFURCATION</u> DUE TO (c) <u>MYOCARDIAL INFARCTION</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 DAY</u> <u>22 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN</u> , 19 <u>66</u> , to <u>18 OCT</u> , 19 <u>66</u> that (I) (the) last saw the deceased alive on <u>18 OCT</u> 19 <u>66</u> and that death occurred at <u>7:30</u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Walter Edgoorth</u>		22b. DATE SIGNED <u>10-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>WALTER EDGOORTH MD</u>		22d. ADDRESS <u>2390 Glenmont Circle, Wheaton, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-20-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elesavetgrad Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, DC</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky & Sons</u>		25. ADDRESS <u>3501-14th St. N.W. Wash. D.C.</u>	
25a. REC'D BY REGISTRAR <u>OCT 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1488

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14393

CERTIFICATE OF DEATH

14393

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>		d. STREET ADDRESS <u>408 Windsor St.</u>	
3. NAME OF DECEASED (Type or print) <u>Norman Garden Kindness</u>		4. DATE OF DEATH <u>October 3, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-1-98</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction Gov't</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Kindness</u>		14. MOTHER'S MAIDEN NAME <u>Georgeanna Robb</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>577-07-4375</u>	
17. INFORMANT <u>Hospital Records</u>		Address <u>7600 Carroll Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>coronary occlusion</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia, Secondary anemia, Emphysema</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July, 1954</u> , to <u>30 October, 1966</u> , that (I) (we) last saw the deceased alive on <u>30 October 1966</u> , and that death occurred at <u>3:10 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u>		22b. DATE SIGNED <u>10-3-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS <u>1106 Spring Street Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Oct. 5, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>
24. FUNERAL DIRECTOR <u>Clark E. Wisor</u>		25a. REC'D BY REGISTRAR <u>Clark E. Wisor</u>	
25b. REGISTRAR'S SIGNATURE <u>Warner E. Pumphrey, Jr.</u>		DATE <u>OCT 6 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14303

RECORDS OF DEATH

14303

14303

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14394

CERTIFICATE OF DEATH

14394

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wheaton c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 11406 Viers Mill Road				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville d. STREET ADDRESS 508 Fletcher Place e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WALTER L KIRK First Middle Last 4. DATE OF DEATH OCT 16 1966 Month Day Year				5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 12/5/99 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Controlman-Eng. Room 10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt-Ret. 11. BIRTH PLACE (County & State, or foreign country) Illinois 12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Jay Bird Kirk 14. MOTHER'S MAIDEN NAME Sadie Tidd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) WW I 16. SOCIAL SECURITY NO. 577-01-8657 17. INFORMANT Wife Address Same as Item 2.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION MASSIVE 4201 DUE TO CORONARY ARTERY DISEASE ANGINA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE ARTERIOSCLEROSIS (c) HEPATIC CIRRHOSIS LIVER DISEASE				INTERVAL BETWEEN ONSET AND DEATH INSTANT YEARS 4			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HEPATIC CIRRHOSIS LIVER DISEASE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/1 , 19 63 , to 10/16 , 19 66 , that (I) (we) last saw the deceased alive on 10/16 , 19 66 , and that death occurred at 10:00 PM from the causes and on the date stated above.				22a. SIGNATURE Charles Farwell 22b. DATE SIGNED 10-16-66 22c. PHYSICIAN'S NAME (Type) CHARLES FARWELL 22d. ADDRESS 11406 Viers Mill Rd. Wheaton, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) 10-19-66 23b. DATE THEREOF 10-19-66 23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem. 23d. LOCATION (City, town or county) (State) Arlington, Virginia				24. FUNERAL DIRECTOR ADDRESS ROBERT A. PUMPHREY, Bethesda, Maryland 25a. REC'D BY REGISTRAR OCT 20 1966 25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14395

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14395

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		c. LENGTH OF STAY IN 1b 30 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 4600 Highland Ave.		d. STREET ADDRESS 4600 Highland Ave.	
3. NAME OF DECEASED (Type or print) First JOHN Middle JAMES Last KLAK		4. DATE OF DEATH Month Oct. Day 1 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17, 1900
9. AGE (In years last birthday) yrs. 65		10. IF UNDER 1 YEAR Months 9 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer		10b. KIND OF BUSINESS OR INDUSTRY Legal	
11. BIRTHPLACE (State or foreign country) Wisconsin		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Ignace Klak		14. MOTHER'S MAIDEN NAME Frances Tomkowiak	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWI & WWII		16. SOCIAL SECURITY NO. 577-48-3967	
17. INFORMANT Ruth H. Klak - Wife - Same Item #2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) with liver metastasis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED Oct. 1, 1966	
ACTUAL SIGNATURE Belden R. Peap M.D. EXAMINER'S NAME (Type) BELDEN R. PEAP, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-5-66	
23c. NAME OF CEMETERY OR CREMATORY Arlington Natl Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR DATE OCT 7 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #23d Film #G382 11/2/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14396

14396

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Centerhill 11907 Centerhill Rd.</u>				d. STREET ADDRESS <u>Centerhill 11907 Centerhill Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>MELVIN</u> Last <u>KLINE</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>17</u> Year <u>1966</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/11/1903</u>	
						9. AGE (In years last birthday) <u>63</u>	
						10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Classified analyst</u>	
						11. BIRTHPLACE (State or foreign country) <u>Altoona, Pennsylvania</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John B. Kline</u>				14. MOTHER'S MAIDEN NAME <u>Snow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-44-3083</u>		17. INFORMANT <u>Dolores C. Kline</u>	
						11907 Centerhill St. Silver Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>John G. Ball</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>7936 Old Georgetown Rd. Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 24 1966</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

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11300

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14397
CERTIFICATE OF DEATH
14397

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Greece</u> b. COUNTY <u>Nomos Kojanis</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>29 Days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Peponia Voiou</u>		d. STREET ADDRESS <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda, Maryland</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lambrini (NMN) Kondossi</u>			4. DATE OF DEATH <u>October 2 19 66</u>			5. SEX <u>Female</u>	
6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>29 July 1948</u>		9. AGE (in years last birthday) <u>18</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u>	
13. FATHER'S NAME <u>Theodosios Kondossi</u>				14. MOTHER'S MAIDEN NAME <u>Anastasia Karamitoboulou</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Records</u> Address <u>The Clinical Center, Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u> 535X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Congestion</u> DUE TO (c) <u>Alveolar hemorrhage & parenchymal injury</u> INTERVAL BETWEEN ONSET AND DEATH <u>36 hours</u> <u>36 hours</u> <u>36 hours</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>circulation</u> <u>Status postoperative Aortic Valve Replacement with extracorporeal/</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year <u>19</u> <u>66</u> Hour a.m. <u>10:50</u> p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that <u>he</u> (this hospital) attended the deceased from <u>3 Sept.</u> , 19 <u>66</u> , to <u>2 Oct.</u> , 19 <u>66</u> , that <u>XIX</u> (we) last saw the deceased alive on <u>2 October</u> 19 <u>66</u> , and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas J. Fogarty</u>				22b. DATE SIGNED <u>2 October 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas J. Fogarty, M.D.</u>				22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4 October 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CONGRESSIONAL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON DC.</u>	
24. FUNERAL DIRECTOR <u>RINALDI FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
ADDRESS <u>2230 12</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>OCT 5 1966</u>							

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

14398

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14398

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY in 1b <u>DOA</u>		d. STREET ADDRESS <u>7213 Spruce ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San + Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First Middle Last <u>KORKISCH</u>		4. DATE OF DEATH Month <u>10</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-82</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Korkisch</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Mader</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578 201 524</u>	
17. INFORMANT <u>John W. Korkisch</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201</u> DUE TO <u>Acute Coronary Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <u>OCT. 10, 1966</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BIRTH, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct. 13-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Lawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Green Lawn Cemetery</u>	
24. FUNERAL DIRECTOR <u>Antonia Nutter, 254 Carroll Rd. N. W. Md. 11C</u>		25a. REC'D BY REGISTRAR <u>John Charles Judge</u>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	
DATE <u>OCT 13 1966</u>			

2021

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14399

CERTIFICATE OF DEATH

14399

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>D. C. (Washington)</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47.3</u> d. STREET ADDRESS <u>5608 Eastern Ave. N.E.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JOHANNES</u> First <u>KURT</u> Middle <u>KOWNATZKI</u> Last		4. DATE OF DEATH Month <u>10</u> Day <u>10</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-24-15</u>
9. AGE (In years lost birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker - Langley Bakery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Germany</u>	
13. FATHER'S NAME <u>Emil Kownatzki</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Hirsch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Hospital records</u>	
17. INFORMANT <u>Hospital records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hypothyroidism</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>Oct. 10</u> , 19 <u>66</u> , that (we) last saw the deceased alive on <u>Oct. 10</u> 19 <u>66</u> , and that death occurred at <u>12:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Norman H. Rubenstein</u>		22b. DATE SIGNED <u>10/10/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Norman H. Rubenstein</u>		22d. ADDRESS <u>6780 N.H. Ave. Tak. Pk, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u>
24. FUNERAL DIRECTOR <u>The S. H. Hines Co. Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>OCT 13 1966</u>	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14400

14400

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK c. LENGTH OF STAY IN 1b 237 hrs, 26 min d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SAN. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK d. STREET ADDRESS 805 LARCH AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAY Middle — Last KRUEGER		4. DATE OF DEATH Oct. 21 1966	
5. SEX FEM.	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-87
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 2 Days 21 Hours 19 Min. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) AUSTRIA		12. CITIZEN OF WHAT COUNTRY? AMERICA	
13. FATHER'S NAME NATHAN PASTERNAK		14. MOTHER'S MAIDEN NAME GERTRUDE ZORHOFF	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT Chart - 7600 Carroll Ave, Takoma Park, Md.		Address —	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive failure. DUE TO 4341 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO — (c) —			INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1962 , 19 800 to 10/21 , 19 66 , that (I) (we) last saw the deceased alive on 10/20 , 19 66 , and that death occurred at 8 A M, from causes and on the date stated above.			
22a. SIGNATURE Ernest A. Sarao MD		22b. DATE SIGNED 10/21/66	
22c. PHYSICIAN'S NAME (Type) ERNESTA. SARAO MD		22d. ADDRESS 7006 NEW HAMPSHIRE AVE TAKOMA PARK	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-23-66	23c. NAME OF CEMETERY OR CREMATORY King David Memorial Garden	23d. LOCATION (City or Town) (County) (State) Falls Church, Va.
24. FUNERAL DIRECTOR Bernard Danzansky and Sons		25a. REC'D BY REGISTRAR Washington DC DATE OCT 24 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-14-44

INVESTIGATION OF DEATH

1-14-44

1-14-44

1-14-44

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14401

CERTIFICATE OF DEATH

14401

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mont. b. COUNTY District of Columbia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Doratha Rutledge KUHN		4. DATE OF DEATH Month Day Year October 6 19 66	
5. SEX Female	6. COLOR OR RACE Cauc	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 18, 1915
9. AGE (In years last birthday) 51 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Pittsburgh, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Rutledge		14. MOTHER'S MAIDEN NAME Hilda Luther	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 193 05 2053	
17. INFORMANT Mr. William C. Kuhn, 5621 Overlea Rd. N.W.		Address D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Breast, Bilateral, with Plural Metastases 170x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Oct. 5, 1966 , to Oct. 6, 1966 , that (X) (we) last saw the deceased alive on Oct. 6, 1966 , and that death occurred at 405PM , from causes and on the date stated above.			
22a. SIGNATURE H. E. Ashworth		22b. DATE SIGNED 7 October 1966	
22c. PHYSICIAN'S NAME (Type) H. E. ASHWORTH, LT MC USN		22d. ADDRESS Naval Hospital, Bethesda, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-10-1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR Joseph Gawler & Sons		25a. REC'D BY REGISTRAR DATE OCT 13 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 5130 Wisconsin Ave., N.W. Washington, D.C.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
14402 CERTIFICATE OF DEATH 14402									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>					c. LENGTH OF STAY IN 1b <u>18 years</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>709 Wayne Avenue</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Carrie</u> Middle <u>May</u> Last <u>Laws</u>					4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sep. 12, 1881</u>		9. AGE (In years last birthday) <u>85</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		
13. FATHER'S NAME <u>Frank Weller</u>					14. MOTHER'S MAIDEN NAME <u>Clara Stockbarger Stockslager</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. G. Moseley</u>		Address <u>709 Wayne Avenue Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial and respiratory failure</u> <u>4341</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary insufficiency</u> (c) <u>Congestive heart failure</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>8-12 months</u> <u>14 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Arteriosclerosis Senility</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 9, 1960</u> to <u>Oct. 18, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct. 18, 1966</u> , and that death occurred at <u>3:00</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>Philip E. Jones</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Oct. 18, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones, M.D.</u>					22d. ADDRESS <u>800 Pershing Dr., S.S., Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Oct. 21, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Catlett Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Catlett, Virginia</u>			
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		ADDRESS <u>8434 Georgia Ave.</u>		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 24 1966</u>	

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #1b & d Film #G382 10/26/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14403

14403

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville, Md.</u>		c. LENGTH OF STAY IN 1b <u>15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6106 Nielwood Dr.</u>		d. STREET ADDRESS <u>6106 Nielwood Dr.</u>	
3. NAME OF DECEASED (Type or print) First <u>Milton</u> Middle <u>Lehman</u> Last <u>Lehman</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>13</u> Year <u>19 66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 24 1917</u>
9. AGE (In years last birthday) yrs. <u>49</u>		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Writer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Writer</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsburg - Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Milton Lehman</u>		14. MOTHER'S MAIDEN NAME <u>Helen Neussbaum</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>170-14-8733</u>	
17. INFORMANT <u>W W TT</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line, or (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO <u>Coronary Artery Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiorespiratory failure due to overdose of</u> (c) <u>barbiturate apparently self-administered</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased apparently took an overdose of a short-acting barbiturate</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>2:00</u> XXXX <u>10/13</u> 19 <u>66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Rockville Montg. Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Fear</u> M.D.		22. DATE SIGNED <u>OCT. 13, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. FEAR, M.D.</u>		Address (Street, city, town, or county) <u>Washington</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>10/14/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>West View, Pitt. Pa.</u>	23d. LOCATION (City or Town) (County) (State) <u>Pittsburgh, Pa.</u>
24. FUNERAL DIRECTOR <u>B. Nangany + Sons</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 17 1966</u>	
ADDRESS <u>3501-14th St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11-11-11

11-11-11



14404

CERTIFICATE OF DEATH

14404

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>		c. LENGTH OF STAY IN lb <u>2 yrs. 10 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wheaton Nursing Home 11901 Georgia Ave.</u>				d. STREET ADDRESS <u>3016 Tilden St. NN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mabel B. Leonard</u>				4. DATE OF DEATH Month Day Year <u>10 11 19 66</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-76</u>	9. AGE (In years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>IOWA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John WRY</u>				14. MOTHER'S MAIDEN NAME <u>MARY WILSON.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>577-66-5894</u>		17. INFORMANT <u>ANNA E. BAINES</u>		Address <u>WASH. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Inanition.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>64</u> to <u>Oct</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Oct. 1</u> , 19 <u>66</u> and that death occurred at <u>1P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Belden R. Reap</u>				22b. DATE SIGNED <u>Oct 11, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>BELDEN R. REAP, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>10-12-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>George Wash. Medical School / Wash. D.C.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>OCT 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Page 3 please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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20240

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14405

CERTIFICATE OF DEATH

14405

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7601 Exeter Road</u>	
3. NAME OF DECEASED (Type or print) <u>E. John</u> First <u>Long</u> Middle <u>Long</u> Last		4. DATE OF DEATH <u>10-24</u> 19 <u>66</u> Month <u>10</u> Day <u>24</u> Year <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-1900</u> 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Publisher-Editor-Writer Ocean Science News</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Tennessee</u>	
13. FATHER'S NAME <u>Jesse Elias Long</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Kenmuir</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>261-40-7876</u>	
17. INFORMANT <u>Wife Virginia W.</u> Address <u>Same</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure, acute and chronic</u> DUE TO (b) <u>Myocardial infarction, remote</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 24</u> , 19 <u>42</u> to <u>Oct 24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 24</u> 19 <u>66</u> , and that death occurred at <u>12:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Leo M. Custis</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>10-24-66</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. Leo M. Custis</u>		22d. ADDRESS <u>8218 Wisconsin Ave, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-27-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Va</u>
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W., Wash. DC.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>OCT 27 1966</u>			

14402

GENERAL CL. DEATH

14402

14402

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14406
CERTIFICATE OF DEATH
14406

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>CORROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Union Bridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Asbury Methodist Home for the Aged, Inc.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Missouri</u> Last <u>Lynn</u>		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 29, 1877</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk & kept house</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>McKinstry's Mills, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Thomas Lynn</u>		14. MOTHER'S MAIDEN NAME <u>Laura Crumpacker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-03-7784</u>	
17. INFORMANT <u>Asbury Methodist Home, Gaithersburg, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rectovaginal fistula</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/25/63</u> , 19 <u>63</u> , to <u>10/6/66</u> , 19 <u>66</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>10/6/66</u> , 19 <u>66</u> , and that death occurred at <u>4:00</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs M.D.</u>		22b. DATE SIGNED <u>10/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Henry C. Scruggs M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-9-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mount View</u>		23d. LOCATION (City, town or county) (State) <u>Union Bridge Md</u>	
24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 11 1966</u>	

1440

1440

Barryman

Recd

George C. Barryman

10/10/60

10/10/60

10/10/60

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14407

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14407

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring				c. LENGTH OF STAY IN 1b 29 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riverdale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital of Silver Spring				d. STREET ADDRESS 5909-60th Avenue			
3. NAME OF DECEASED (Type or print) First Charles Middle R. Last MacDonald				4. DATE OF DEATH Month October Day 29 Year 1966			
5. SEX Male		6. COLOR OR RACE Caucasian		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1920 10-17-21	
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William MacDonald		14. MOTHER'S MAIDEN NAME Ella Ingram			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army WWII		16. SOCIAL SECURITY NO.		17. INFORMANT Wife (Mrs. Agnes M. MacDonald (above address))			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary artery heart disease DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Belden R. Reap, M.D.				22. DATE SIGNED 10/29/1966			
EXAMINER'S NAME (Type) BELDEN R. REAP, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/2/66		23c. NAME OF CEMETERY OR CREMATORY Arl. Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Va.	
24. FUNERAL DIRECTOR Nailey's Funeral Home Inc.				ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR DATE NOV 4 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT.

14408

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14408

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. LENGTH OF STAY IN 1b <u>??</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10401 Grosvenor Pl.</u>		d. STREET ADDRESS <u>Rockville</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ann</u> Middle <u>E.</u> Last <u>MANTZ</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 3 1912</u>
9. AGE (In years last birthday) yrs. <u>54</u>		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>29</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William A. Edelblut</u>		14. MOTHER'S MAIDEN NAME <u>Grace L. Bradley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>G. Earl Mantz - Husband - Same as Item #2</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>9020 Injuries, Multiple severe</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Fall, seventeen stories</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Jumped from 17th Floor of Apartment</u>	
20c. TIME OF INJURY Month, Day, Year <u>10:30 a.m. 10/2 1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apartment</u>		20f. (City or town) (County) (State) <u>Rockville Mont Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>10/3/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>Oct. 4, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Bethesda, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14409

CERTIFICATE OF DEATH

14409

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit may be removed from the certificate and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>47.3</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
c. LENGTH OF STAY IN 1b <u>2 Months 9 Days</u>		d. STREET ADDRESS <u>926 Mass. Ave. N.W.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Fairland Nursing Home</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>(Bessie) Elizabeth Lyons Martin</u>		4. DATE OF DEATH <u>October 9 19 66</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/20/02</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Book Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New York City, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Lyons</u>		14. MOTHER'S MAIDEN NAME <u>Anne Barry</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Gertrude Lyons</u>		Address <u>283 West 11th St. New York City, N.Y.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Postnecrotic Cirrhosis</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>D. obles Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 2</u> , 19 <u>66</u> , to <u>October 9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 9</u> , 19 <u>66</u> , and that death occurred at <u>10:00 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Boris Rabkin</u>		22b. DATE SIGNED <u>10/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>BORIS RABKIN</u>		22d. ADDRESS <u>1019 Univ. Blvd E S.S.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>		23b. DATE THEREOF <u>10/11/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>New York City, N.Y.</u>	
24. FUNERAL DIRECTOR <u>The Hines Co</u>		ADDRESS <u>2901 14th St. N.W.</u>	
25a. REC'D BY REGISTRAR <u>DATE OCT 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Walter J. Judge</u>	

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Blank ledger page with horizontal ruling lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14410

CERTIFICATE OF DEATH

14410

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 hours</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>261 Congressional Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Pearl C. Mason</u>		4. DATE OF DEATH Month <u>10</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/7/15</u>
9. AGE (In years last birthday) <u>51</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New York N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry Slikman</u>		14. MOTHER'S M maiden name <u>May Shanks</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sandra Thompson Rockville Md</u>		Address <u>259 Congressional</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>410X VENTRICULAR FIBRILLATION</u> DUE TO <u>MITRAL INSUFFICIENCY, MITRAL STENOSIS, AIO</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CHRONIC RHEUMATIC HEART DISEASE WITH AS</u> DUE TO (c) <u>RHEUMATIC FEVER</u>		INTERVAL BETWEEN ONSET AND DEATH <u>IMMED</u> <u>30 YEARS</u> <u>" "</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>10/28/66</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>10/28/66</u> , 19 <u> </u> , and that death occurred at <u>2:38</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Frederick S Caldwell</u>		22b. DATE SIGNED <u>10/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK S CALDWELL</u>		22d. ADDRESS <u>7000 WOOD ROCKVILLE MARYLAND</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-31-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>NOV 1 1966</u>	

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UNITED STATES DEPARTMENT OF THE INTERIOR

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250
OFFICE OF THE ASSISTANT SECRETARY
FOR LAND MANAGEMENT
14441

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14411

CERTIFICATE OF DEATH

14411

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 29 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		e. STREET ADDRESS 2105 Oakwood Street	
3. NAME OF DECEASED (Type or print) Jose		4. DATE OF DEATH Month Oct. Day 21 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1882
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butler		10b. KIND OF BUSINESS OR INDUSTRY private home	
11. BIRTHPLACE (County & State, or foreign country) Philippine Islands		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes		16. SOCIAL SECURITY NO. 579-48-7733A	
17. INFORMANT Hillcrest		Address Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastrointestinal hemorrhage DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Perforation urinary bladder with recto-vesical fistula			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from Sept. 22, 19 66 , to Oct. 21, 19 66 that (X) (we) last saw the deceased alive on Oct. 2, 19 66 , and that death occurred at 4:54 A. M, from causes on and on the date stated above.			
22a. SIGNATURE <i>L. A. Jones</i>		22b. DATE SIGNED 21 Oct. 1966	
22c. PHYSICIAN'S NAME (Type) L. A. Jones, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 25, 1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. ADDRESS Simmons Brothers Funeral Home		25a. REC'D BY REGISTRAR OCT 24 1966	
1661 Goodhope Road, S.E. Washington, D. C.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14111

14111

UNITED STATES OF AMERICA

Department of State

Office of the Secretary

Washington, D.C.

(Room 1)

Mr. [Name]

Mr. [Name]

Subject:

Re:

Reference is made to

your letter of

dated [Date]

concerning

the above

matter.

Very truly yours,

[Signature]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

[Text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

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MONTGOMERY MARYLAND											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
14412 CERTIFICATE OF DEATH 14412											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montg.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>GERMANTOWN - MD.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ELEN L. McDONALD</u>						4. DATE OF DEATH <u>10-6-1966</u>					
5. SEX <u>F.</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-27-07</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES ROBINSON</u>						14. MOTHER'S MAIDEN NAME <u>LOUISE FOWLER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Edward B. McDonald</u> Address <u>Seneca Rd. Germantown</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MESENTERIC INFARCTION, EMBOLIC</u> 410X } DUE TO (b) <u>RHEUMATIC HEART DISEASE, MITRAL STENOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>2 WKS</u> <u>DECADES</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGENITAL HYPPLASIA OF THE LOWER ABDOMINAL AORTA</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9-21</u> , 19 <u>66</u> , to <u>10/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/6</u> , 19 <u>66</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard H. Pollen</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/7/66 md.</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>						22d. ADDRESS <u>10400 CONNECTICUT AVE, KENSINGTON</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF <u>Oct 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROCK CREEK CEMETERY WASHINGTON, D.C.</u>		23d. LOCATION (City, town or county) (State) <u>WASHINGTON, D.C.</u>			
24. FUNERAL DIRECTOR <u>Arthur Valters</u>				ADDRESS <u>254 Carroll St.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>OCT 11 1966</u>											

14119

14119

ROCK CREEK CEMETERY, WASHINGTON, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14413

CERTIFICATE OF DEATH

14413

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		e. STREET ADDRESS 9600 Forest Road	
3. NAME OF DECEASED (Type or print) First Sister Edward Middle McHugh Last 4. DATE OF DEATH Month Oct Day 31 Year 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1883
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 11 Days 30	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher		10b. KIND OF BUSINESS OR INDUSTRY Catholic Sister	
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Patrick McHugh		14. MOTHER'S MAIDEN NAME Nora Cullinane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Ursuline Convent Records		Address Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular collapse 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis, genit DUE TO (c) Carcinoma ascending Colon			INTERVAL BETWEEN ONSET AND DEATH 14 hrs 2 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March, 1956 , to present , that (I) (we) last saw the deceased alive on 10/30 1966 , and that death occurred at 2:50 p.m. from causes and on the date stated above.			
22a. SIGNATURE Charles Savarese M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 10/31/66
22c. PHYSICIAN'S NAME (Type) CHARLES SAVARESE, M.D.		22d. ADDRESS 11625 Rockville Pike, Rockville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11-3-66	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR NOV 1 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Items 18-21 Film 383 12-19 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G382 11/17/66 mh

14414

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14414

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Former Hyattsville Washington 47-3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>1551 Newton Street N.E. Hyattsville D.C. Home</u>			
3. NAME OF DECEASED (Type or print) <u>Maggie Young McLean</u>				4. DATE OF DEATH <u>October 31</u> 19 <u>66</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/9/69</u>	
9. AGE (In years last birthday) <u>97</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Texas</u>	
13. FATHER'S NAME <u>Wesley D. Young</u>				14. MOTHER'S MAIDEN NAME <u>Armina Ivy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>579-60-0911</u>		17. INFORMANT <u>John H. McLean</u> , Address <u>3506 16th St. N.E.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary embolus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>following a fall</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased fell in Nursing Home</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>Noon 10-22-66</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home</u>	
				20f. (City or town) <u>Hyattsville</u> (County) <u>Pr. Geo.</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>10/31/1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/2/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City or Town) <u>Suitland, Md.</u> (County) (State)	
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>				25a. REC'D BY REGISTRAR <u>NOV 3</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14415 **CERTIFICATE OF DEATH** **14415**

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Kensington 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 4220 Everett Street		d. STREET ADDRESS 4220 Everett Street	
3. NAME OF DECEASED (Type or print) First Genevieve Middle Nickel Last Meese		4. DATE OF DEATH Month October Day 8 Year 1966	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 23, 1894
9. AGE (in years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frederick Nickel		14. MOTHER'S MAIDEN NAME - Jordan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes give war or dates of service) WWI		16. SOCIAL SECURITY NO. 578-14-7388	
17. INFORMANT Address Norman S. Meese same as above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO (b) Atherosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-15- , 1966, to 10-8 , 1966, that (I) (we) last saw the deceased alive on 9-15- , 1966, and that death occurred at 10⁰⁰ A.M. , from the causes and on the date stated above.			
22a. SIGNATURE Stephen W. DeJeter		22b. DATE SIGNED 10-8-1966	
22c. PHYSICIAN'S NAME (Type) STEPHEN W. DEJETER		22d. ADDRESS 6719 W. ZENSON LANE, BETHESDA, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/11/66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City, town or county) (State) Arlington, Va.
24. FUNERAL DIRECTOR The S. H. Hines Company- Washington, DC		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 11 1966			

1941

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14416

CERTIFICATE OF DEATH

14416

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DIST. OF COL. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTON D.C.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM & HOSPITAL		d. STREET ADDRESS 1725 17th St NW APT. 106	
3. NAME OF DECEASED (Type or print) First MARTHA Middle Louise Last MENK		4. DATE OF DEATH Month Oct. Day 7 Year 1966	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-23-83
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME Rudolph MENK		14. MOTHER'S MAIDEN NAME ELISE FISCHER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. - - -	
17. INFORMANT HOSPITAL RECORDS - W.S.H.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary atherosclerosis Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Poss. G.I. tract Malignancy, Septicemia			INTERVAL BETWEEN ONSET AND DEATH
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-19, 1966 to 10-7, 1966 that (I) (we) last saw the deceased alive on 10-7, 1966 and that death occurred at 5:35 PM , from causes and on the date stated above.			
22a. SIGNATURE Gilbert B. Cushman M.D.		22b. DATE SIGNED 10-7-66	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS ?	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 10-10-1966	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory Suitland, Md.	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wise Ave. N.W. Wash. DC.		25a. RECEIVED BY REGISTRAR OCT 13 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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~~Robert B. Cooper~~

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14417

14417

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>			d. STREET ADDRESS <u>1213 Harding Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Anita</u> Middle <u>Jean</u> Last <u>Merson</u>			4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1966</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 6, 1906</u>		9. AGE (In years last birthday) yrs. <u>60</u> IF UNDER 1 YEAR Months <u>13</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>William E. Merson</u>			14. MOTHER'S MAIDEN NAME <u>Linda Jean Schell</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Atelectasis</u> 7625 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Prematurity</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-6</u> , 19 <u>66</u> , to <u>10-6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-6</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Carl Silverman</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Carl Silverman</u>		22d. ADDRESS <u>12801 EVANSTON ST. ROCKVILLE, Md.</u>			
23a. BURIAL, CREMATION, or other disposition (Specify)	23b. DATE THEREOF <u>10/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>Rockville, Md.</u>		25. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**FOR STATE
HEALTH DEPT.**

14418

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14418

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15.1	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>4904 ASBURY LANE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HENRY IRWIN METZ</u>		4. DATE OF DEATH <u>Oct. 26</u> 19 <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/04</u> 62 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Radio Eng</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NASA</u>	11. BIRTHPLACE (State or foreign country) <u>Penn.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Frederick Metz</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Blatz</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>577-56-6840</u>		17. INFORMANT <u>Wife Rose Metz (same as above)</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Burns, 2nd and 3rd degree, 61% body area</u> 9160 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Can of charcoal lighter. ignited excluded, igniting clothing</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> p.m. <u>10/22</u> 19 <u>66</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Bethesda</u> (County) <u>Mont.</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 10/27/66	
		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-29-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>	23d. LOCATION (City or Town) <u>Silver Spring, Maryland</u> (County) (State)
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 1</u> 19 <u>66</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14419

CERTIFICATE OF DEATH

14419

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>49 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U.S. Naval Hospital, Bethesda, Maryland</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY _____ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mc Lean</u> d. STREET ADDRESS <u>6518 Dryden Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carl Ernest MILLER</u>			4. DATE OF DEATH Month Day Year <u>October 15 19 66</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>16 July 1908</u>		9. AGE (In years last birthday) <u>58</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronics Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (County & State, or foreign country) <u>Alexander, North Carolina USA</u>			
13. FATHER'S NAME <u>Obe Miller</u>			14. MOTHER'S MAIDEN NAME <u>Myrtle Teague</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1925-1955</u>		16. SOCIAL SECURITY NO. <u>227-48-8298</u>		17. INFORMANT <u>6518 Dryden Drive Mrs. Thelma Miller Mc Lean, Virginia</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchogenic carcinoma with wide spread metastases</u> DUE TO (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH _____		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
_____		_____		_____			
21. I certify that (I) (this hospital) attended the deceased from <u>6 September, 19 66</u>, to <u>15 October 1966</u>, that (I) (we) last saw the deceased alive on <u>15 October 19 66</u>, and that death occurred at <u>935A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William L. Brannon, Jr.</u>				22b. DATE SIGNED <u>17 October 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>William L. Brannon, Jr. LCDR MC</u>				22d. ADDRESS <u>U.S. Naval Hospital, Bethesda, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>			
_____		_____		_____			
24. FUNERAL DIRECTOR <u>R.A. Pumphrey Funeral Home Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14420

CERTIFICATE OF DEATH

14420

1. PLACE OF DEATH a. COUNTY Montgomery		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b 6 days.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gaithersburg, Md.		15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital				d. STREET ADDRESS 621 N. Frederick Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Esther Mae Miller		First Middle Last		4. DATE OF DEATH Month Day Year Oct. 6 19 66			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 5-29-07 1900		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Earp				14. MOTHER'S MAIDEN NAME Lou Jefferson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-52-9524		17. INFORMANT Montgomery Gen. Hospital		Address Olney, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Intraabdominal infection of stating the underlying cause lost. (c) undetermined source						INTERVAL BETWEEN ONSET AND DEATH 6 days 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Diabetic Mellitus - Obesity						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1 , 19 66 , to Oct 6 , 19 66 , that (I) (we) last saw the deceased alive on Oct 5 , 19 66 , and that death occurred at 5:15am , from causes and on the date stated above.							
22a. SIGNATURE Dr. A. D. Bonifant				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. A. D. Bonifant				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-8-66		23c. NAME OF CEMETERY OR CREMATORY McKormick		23d. LOCATION (City or Town) (County) (State) Germantown mont Md	
24. FUNERAL DIRECTOR Ernest C. Gartner				25a. REC'D BY REGISTRAR DATE OCT 10 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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0004-0014

FOR STATE
HEALTH DEPT.

14421

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14421

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 23 days/11hrs.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE D. C. b. COUNTY Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium & Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Minnie Middle Bickel Last Miller			4. DATE OF DEATH Month October Day 3 Year 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-24-75		9. AGE (In years last birthday) yrs. 91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
13. FATHER'S NAME WILLIAM BICKEL				14. MOTHER'S MAIDEN NAME FREDERICKA APFELBACH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 167-05-1243		17. INFORMANT Hospital Records Address 7600 Carroll Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pulmonary embolus 465x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arising from left leg. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Beloen R. Reap		M.D.		22. DATE SIGNED Oct. 3, 1966	
EXAMINER'S NAME (Type) BELOEN R. REAP, M.D.		DEPUTY MEDICAL EXAMINER Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Oct-6-1966 Voegtlay		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Allegany Co. Cemetery	
24. FUNERAL DIRECTOR Arthur Walters		ADDRESS 254 Carroll St		25a. REC'D BY REGISTRAR DATE OCT 6 1966	
				25b. REGISTRAR'S SIGNATURE Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

Cleared with Dr. Barber

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
14422				CERTIFICATE OF DEATH				14422			
1. PLACE OF DEATH a. COUNTY <u>Montgomery Co.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>				c. LENGTH OF STAY IN 1b <u>36 hrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> <u>151</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp of S.S. Md.</u>						d. STREET ADDRESS <u>14015 Layhill Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frazier</u> Middle <u>Newton</u> Last <u>Montgomery, Jr</u>						4. DATE OF DEATH Month <u>10</u> - Day <u>2</u> Year <u>1966</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-30-66</u>		9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> Hours <u>7</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frazier Montgomery</u>						14. MOTHER'S MAIDEN NAME <u>Redman Elizabeth - 14015 Layhill Rd. - S.S., Md.</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Chart</u> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural hematoma</u> <u>7600</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>7600</u> DUE TO (c) <u>7600</u>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/1/66</u> , 19 <u>66</u> , to <u>10/2/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/2/66</u> , 19 <u>66</u> , and that death occurred at <u>6:40</u> M, from causes and on the date stated above.											
22a. SIGNATURE <u>Richard J. Hollander</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/2/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Hollander</u>						22d. ADDRESS <u>1110 Spring Street Montgomery Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-6-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dickerson</u>				23d. LOCATION (City or Town) (County) (State) <u>Dickerson, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> <u>Laytonsville, Md.</u>						25a. REC'D BY REGISTRAR DATE <u>OCT 11 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11133

DEPARTMENT OF HEALTH

11133

Director, D. H. A.

Washington, D. C.

11-1-33

11-1-33

Charles A. Barber, M.D., M.P.H.

11-1-33

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

(M)

MD
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14423

CERTIFICATE OF DEATH

14423

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital, Olney, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Spencerville	
d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Kenneth Russell Moore		4. DATE OF DEATH Month 10 Day 20 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/21/08
9. AGE (In years lost birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Trash Disposal	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown Nathaniel Moore		14. MOTHER'S MAIDEN NAME Unknown Della Williams	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-14-8204	
17. INFORMANT Family, Spencerville, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) In 10 Cardiac Infarction - Postoperative DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Occlusion - (P) Coronary Artery DUE TO Atherosclerosis - Coronary Artery - Severe (c) Hyperkalemia - mild, Essential		INTERVAL BETWEEN ONSET AND DEATH hours hours -days years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) Hyperkalemia - mild, Essential		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 8 , 19 62 to OCT 17 , 19 66 (I) (we) last saw the deceased alive on OCT 17 , 19 66 , and that death occurred at 7:35 PM , from causes and on the date stated above.			
22a. SIGNATURE John R. Spencer		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) John R. Spencer		22d. ADDRESS 15444 Columbia Rd., Burtonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/23/66	
23c. NAME OF CEMETERY OR CREMATORY Burtonsville Mt. Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Dewitt Donaldson		25. REC'D BY REGISTRAR Charles Judge	
25a. ADDRESS 318 Calhoun Ave		25b. REGISTRAR'S SIGNATURE Charles Judge	
DATE OCT 25 1966			

2268

531-1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14424

CERTIFICATE OF DEATH

14424

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb <u>5 days</u>	
d. NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>		e. STREET ADDRESS <u>4810 Eastern Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>NINA</u> Middle <u>A</u> Last <u>MORT</u>		4. DATE OF DEATH Month <u>October</u> Day <u>25</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-10-1894</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		9b. AGE (In years last birthday) <u>72</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ward Algate</u>		14. MOTHER'S MAIDEN NAME <u>Lois Danley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Betty Gray</u>		Address <u>4810 Eastern Lane Suitland Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> <u>1992</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CARCINOMA OF Sigmoid and Bladder</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized ARTERIO SCLEROSIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/20</u> , 19 <u>66</u> , to <u>10/25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10/24</u> 19 <u>66</u> , and that death occurred at <u>1242</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond T. Benack</u>		22b. DATE SIGNED <u>10/25/65</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>		22d. ADDRESS <u>4115 Colie Drive, Wheaton Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-29-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lauderdale Mem. Gardens</u>		23d. LOCATION (City or Town) (County) (State) <u>Fort Lauderdale Florida</u>	
24. FUNERAL DIRECTOR <u>Wilhelm Funeral Home</u>		25a. REC'D BY REGISTRAR <u>OCT 27 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

ASL-1

1544

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14425

CERTIFICATE OF DEATH

14425

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>13 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>5822 Lone Oak Dr</u>	
3. NAME OF DECEASED (Type or print) First <u>Ross</u> Middle <u>A.</u> Last <u>Mossburg</u>		4. DATE OF DEATH Month <u>Oct.</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-24-14</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Schedule Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C. Transit</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles W. Mossburg</u>		14. MOTHER'S MAIDEN NAME <u>Lelia E. Poole</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-10-5072</u>	
17. INFORMANT <u>Betty R. Mossburg</u> Address <u>Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal hemorrhage</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture, esophageal varices</u> DUE TO (c) <u>Cirrhosis, liver</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Massive ascites, hypo proteinemia</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10-3-</u> , 19 <u>66</u> , to <u>10-13-</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>10-13-</u> , 19 <u>66</u> , and that death occurred at <u>5:30</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Linwood H. Johnson Jr.</u> M.D.		22b. DATE SIGNED <u>10-14-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>LINWOOD H. JOHNSON JR.</u>		22d. ADDRESS <u>4405 E-W Highway, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-17-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	23d. LOCATION (City or town) (County) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 19 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

14452

RECEIVED

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14452

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14426

CERTIFICATE OF DEATH

14426

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>11 hrs. 35 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Maryland</u>	
3. NAME OF DECEASED (Type or print) First <u>Louis</u> Middle <u>E.</u> Last <u>Mundy</u>		d. STREET ADDRESS <u>4418 Ambler Drive</u>	
4. DATE OF DEATH Month <u>10</u> Day <u>31</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/15/92</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>16</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Gov.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Mundy</u>		14. MOTHER'S MAIDEN NAME <u>Mathilda Krebbs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-60-4176</u>	
17. INFORMANT <u>Daughter</u>		Address <u>Mrs. Ira Shoemaker Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>177X</u> DUE TO <u>Cancer of Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u></u> (c) DUE TO <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arteriosclerosis</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u></u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/1/65</u> to <u>10/31</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>10/31</u> 19 <u>66</u> , and that death occurred at <u>725</u> A.M. from causes and on the date stated above.			
22a. SIGNATURE <u>John J. Curry M.D.</u>		22b. DATE SIGNED <u>11/1/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN J. CURRY</u>		22d. ADDRESS <u>10620 Georgia Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D. C.</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 7 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1992

2021

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14427

CERTIFICATE OF DEATH

14427

1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN lb 1 mo.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Morningside	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University Nursing Home				d. STREET ADDRESS 5717 Offutt Drive	
3. NAME OF DECEASED (Type or print) John Francis Nassif		4. DATE OF DEATH 10 - 23 - 1966		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/1897	9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tool maker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Stamford, Connecticut	
13. FATHER'S NAME Joseph			14. MOTHER'S MAIDEN NAME Mary Farhart		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Ann Moreno 4900 O Street Hillside, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Cecum 1530 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 1 year.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from Oct 1 , 19 65 , to Oct 23 , 19 66 , that (I) (we) last saw the deceased alive on Oct 23 , 19 66 , and that death occurred at 8:15 P.M., from causes and on the date stated above.					
22a. SIGNATURE William Brainin		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/23/66	
22c. PHYSICIAN'S NAME (Type) William Brainin, M. D.		22d. ADDRESS 6124 Central Ave., Capitol Heights, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/27/66	23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEMETERY	23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.		
24. FUNERAL DIRECTOR WILHELM FUNERAL HOME ADDRESS 2800 SWILLAND RD. SUITLAND MD.			25a. REC'D BY REGISTRAR DATE OCT 27 1966	25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10457

CENTRAL DE LOATH

10457

1 no.

University Nursing Home

City of New York

John Francis Heston

White

Married

Tool maker

Stamford, Connecticut

Joseph

Harry Richard

Unknown

NEW YORK CITY

William Hamilton K. T.

154 Central Ave., Capital Hill, N.Y.

OCT 27 1966

James J. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
14428											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>1 MONTH, 9 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>FAIRLAND NURSING HOME FAIRLAND RD.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>FR. GEO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Laurel</u> d. STREET ADDRESS <u>Route 2 - Box 117</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Albert BEYARD Neal</u>			First Middle Last		4. DATE OF DEATH <u>10 - 16 1966</u>		Month Day Year				
5. SEX <u>male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-20-1877</u>		9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gov't Emp.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>I</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WM. OSCAR NEAL</u>					14. MOTHER'S MAIDEN NAME <u>Josephine Boswell</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>215-38-7140</u>		17. INFORMANT <u>Mr. Oscar T. Neal - St. Mt. Rainier, Md.</u>		Address <u>4104 - 31st</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia & Cardiac failure</u> <u>4500</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Upper Respiratory Infection</u> DUE TO (c) <u>Arteriosclerosis</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>10-16</u> , 1966, that (I) (we) last saw the deceased alive on <u>9-22</u> 1966, and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Edolo Pierandrei</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-16-66</u>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>10/19/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Com.</u>		23d. LOCATION (City, town or county) (State) <u>Colmar Manor, Md.</u>				
24. FUNERAL DIRECTOR <u>Nalley's</u>			ADDRESS <u>Mt. Rainier, Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 20 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
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<div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div>14429</div> <div> <div>1</div> <div>2</div> </div> </div> <div> <div>14429</div> <div> <div>1</div> <div>2</div> </div> </div>											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY MONTGOMERY						a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda						b. COUNTY MONTGOMERY					
c. LENGTH OF STAY IN 1b D.O.A.						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GAITHERSBURG					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Suburban						d. STREET ADDRESS Route 3					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
Philip			Noland			Oct			1 1966		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
MALE	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Sept. 13, 1914	52 yrs.	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER			10b. KIND OF BUSINESS OR INDUSTRY -			11. BIRTHPLACE (State or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME George Noland						14. MOTHER'S MAIDEN NAME NETTIE MACABEE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) yes - 2nd W-W			16. SOCIAL SECURITY NO.			17. INFORMANT Address Anna Paris - sister - SAME -					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonitis, probable											
5271 DUE TO (b) viral origin, generalized.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Emphysema											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Belden R. Heap						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) BELDEN R. HEAP M.D.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER Wheeler						DATE SIGNED Oct. 1, 1966					
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			22b. DATE THEREOF 10/6/66			22c. NAME OF CEMETERY OR CREMATORY Arlington National			22d. LOCATION (City, town, or county) (State) Arlington VA.		
23. FUNERAL DIRECTOR Robert L. Snouden, Rockville, Md						24a. REC'D BY REGISTRAR DATE OCT 6 1966					
24b. REGISTRAR'S SIGNATURE J. Charles Judge											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

14430

CERTIFICATE OF DEATH

14430

Item Id Film G381 10/17/66 mh

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Beallsville c. LENGTH OF STAY IN 1b 6 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Rt. #109			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montg. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier d. STREET ADDRESS 4107 - 28th St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CORA Ellen NORRIS First Middle Last			4. DATE OF DEATH OCTOBER 8 1966 Month Day Year		
5. SEX Fem.		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Sept. 9. 1880		9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Harry Bowman			14. MOTHER'S MAIDEN NAME Catherine Darby		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)			16. SOCIAL SECURITY NO. 220-48-9516C		
17. INFORMANT W. Norris			Address Beallsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HYDROSTATIC PNEUMONIA DUE TO (b) ARTERIOSCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 week years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 12:00 pm 1966 to Oct 8 1966 that (I) (we) last saw the deceased alive on Oct 8 1966 and that death occurred at 11:30 AM from the causes and on the date stated above.					
22a. SIGNATURE <i>John G. Fawcett</i> M.D.			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) John G. Fawcett			22d. ADDRESS Boys, Mary, and.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/66		23c. NAME OF CEMETERY OR CREMATORY Monocacy	
23d. LOCATION (City, town or county) Beallsville		(State) Md.		23e. REC'D BY REGISTRAR	
23f. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE OCT 13 1966		23g. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Constance C. Hilton</i>			ADDRESS Barnesville, Md		

MEDICAL CERTIFICATION

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STATE OF TEXAS

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THE STATE OF TEXAS

COUNTY OF DALLAS

CITY OF DALLAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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14431

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14431

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New York b. COUNTY Westchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Poolesville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 1225 Midland Avenue 69-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reddick Road - Red Oak Farms		d. STREET ADDRESS Bronxville, New York	
3. NAME OF DECEASED (Type or print) First Geraldine Middle Carlie Last OBERHAMMER		4. DATE OF DEATH Month October Day 5 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 15, 1910
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 0 Days 20 Hours Min. 	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Receptionist		11b. KIND OF BUSINESS OR INDUSTRY ?	
11. BIRTHPLACE (County & State, or foreign country) New York City, N. Y.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel P. Heap		14. MOTHER'S MAIDEN NAME Edna C. Schlater	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 061-10-3650	
17. INFORMANT Daughter		Address Mrs. Sandra O. Karn, Poolesville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia, Bacterial 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastatic Carcinoma DUE TO (c) Carcinoma of Right Breast		INTERVAL BETWEEN ONSET AND DEATH 4 1/8 hours 3 months 16 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 17 Aug., 1966 , to 5 Oct., 1966 , that (I) (we) last saw the deceased alive on 4 Oct. 1966 , and that death occurred at 6:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Gordon M. Smith		22b. DATE SIGNED 5 Oct 66	
22c. PHYSICIAN'S NAME (Type) Gordon M. Smith, M.D.		22d. ADDRESS Barnesville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Bur-transit		23b. DATE THEREOF 10/5/1966	
23c. NAME OF CEMETERY OR CREMATORY Beachwood Cemetery		23d. LOCATION (City or Town) (County) (State) New Rochelle New York	
24. FUNERAL DIRECTOR Robert A. Pumphrey		25a. REC'D BY REGISTRAR Bethesda, Maryland	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 7 1966	

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Wm. H. Smith

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 14432 CERTIFICATE OF DEATH 14432									
1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bethesda 15-1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5604 Pollard Rd.					d. STREET ADDRESS 5604 Pollard Rd.				
3. NAME OF DECEASED (Type or print) First FRANK Middle E. Last O'CONNELL, JR.					4. DATE OF DEATH Month Oct. Day 22, Year 19 66				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 19, 1915		9. AGE (In years last birthday) 51 yrs.	
						IF UNDER 1 YEAR Months 9 Days 3 Hours Min. 		IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ass't Secy. Home Building Assoc.					10b. KIND OF BUSINESS OR INDUSTRY Virginia			12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frank E. O'Connell, Sr.					14. MOTHER'S MAIDEN NAME Mamie Gogan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII					16. SOCIAL SECURITY NO. 579-44-2752		17. INFORMANT father Address Same as Item 2.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4201 DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus, morrhosis of liver INTERVAL BETWEEN ONSET AND DEATH few hours years									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct. 2, 1949 to 10-22-1966 , that (I) (we) last saw the deceased alive on 10-22-1966 , and that death occurred at 6 A.M. from the causes and on the date stated above.									
22a. SIGNATURE C P Ryland					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10-22-66		
22c. PHYSICIAN'S NAME (Type) C P RYLAND					22d. ADDRESS 4400-49 St. NW. Washington DC				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-26-66		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cem.		23d. LOCATION (City, town or county) (State) Richmond, Virginia			
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland					25a. REC'D BY REGISTRAR OCT 26 1966		25b. REGISTRAR'S SIGNATURE f Charles Judge		

14432

14432

DEPARTMENT OF DEATH

Married

Married

Married

Married

Married

Married

FRANK E. O'CONNELL, JR.

Male

Male

Asst. Secy. Home Building Assoc.

Married

Frank E. O'Connell, Sr.

Married

Male

Married

Frank E. O'Connell, Sr.

Richmond, Virginia

St. Albans, Vermont

10-25-20

1920

Married

Married

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14433

CERTIFICATE OF DEATH

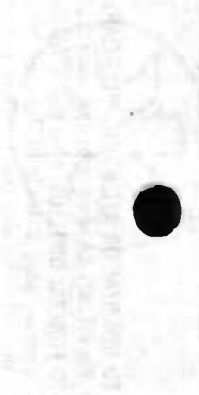
14433

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>16 Hrs 30 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>4403 Franklin St.</u>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>T.</u> Last <u>Oest</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>8</u> Year <u>1966</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>7-17-10</u>		9. AGE (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Credit Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Suburban Trust Co.</u>		11. BIRTHPLACE (County & State or foreign country) <u>NEW JERSEY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William H. Oest</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Wehmann</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-24-1873</u>		17. INFORMANT <u>Wife - Dorothy C. Oest</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Oct. 6</u> , 19 <u>66</u> , to <u>Oct. 8</u> , 19 <u>66</u> that (2) (we) last saw the deceased alive on <u>Oct. 8</u> , 19 <u>66</u> , and that death occurred at <u>2:00 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>John R. Grew MD</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-8-66</u>	
22c. PHYSICIAN'S NAME (Type) _____				22d. ADDRESS <u>916 19th St. N.W. Wash. DC.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-12-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery/ Silver Spring, Md.</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash. DC.</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 13 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1443

1443



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14434

CERTIFICATE OF DEATH

14434

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>17 hr 45 min</u> <u>Hyattsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. & Hosp.</u>		d. STREET ADDRESS <u>2218 Charleston Place</u>	
3. NAME OF DECEASED (Type or print) <u>First ELLA Middle MAY Last OSSENFORT</u>		4. DATE OF DEATH <u>Oct. 30 1966</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/27/90</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES MORRISON</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE IRVINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)	
17. INFORMANT <u>HOSPITAL RECORDS</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Arteriosclerotic cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>unknown</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 25, 1960</u> , to <u>Oct. 30, 1966</u> , that (I) (we) last saw the deceased alive on <u>Oct 30 1966</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u>		22b. DATE SIGNED <u>10-31-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>831 University Blvd. E. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 2, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Greenfield Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hempstead, L.I. New York</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>		25a. REC'D BY REGISTRAR <u>NOV 1 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>254 Carroll St. N.W. Washington, D.C.</u>	

14434

STATE OF TEXAS

14434

15 MONTHS OF VIOLATION
TO IMPROVE THE
LAW OF THE STATE

2014

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

14435

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14435

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring,		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital		d. STREET ADDRESS 4022 Jeffrey Street	
3. NAME OF DECEASED (Type or print) William First Richard Middle PELLEU Last		4. DATE OF DEATH Month 6 , Day October , Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 23, 1928
9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months 10 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President		10b. KIND OF BUSINESS OR INDUSTRY Insurance Agency	
11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME George B. Pelleu, Sr.		14. MOTHER'S MAIDEN NAME Lucille Merryman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Korean		16. SOCIAL SECURITY NO. 212-2442517	
17. INFORMANT Wife Address Phyllis L. Pelleu Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension, Essential DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Belden R. Roap M.D.		22. DATE SIGNED OCT. 6, 1966	
EXAMINER'S NAME (Type) BELDEN R. ROAP, M.D.		DEPUTY MEDICAL EXAMINER Wheaton Address (Street, City, Town, or County)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-10-66	23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery	23d. LOCATION (City or Town) (County) (State) Rockville, Maryland
24. FUNERAL DIRECTOR ROBERT A. PUMPHREY, Bethesda, Maryland		25a. REC'D BY REGISTRAR OCT 10 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

14436

14436

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB <u>3 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>13120 Beaver Terrace</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>13120 Beaver Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Katherine Frances Pendergast</u>		4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1966</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u>			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Sept 23, 1880</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>86</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Office Manager</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>United Ice & Coal Co.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Harrisburg, Penna.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Peter Pendergast</u> 14. MOTHER'S MAIDEN NAME <u>Susanna Donnelly</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> 16. SOCIAL SECURITY NO. <u>195-07-9480</u> 17. INFORMANT <u>Paul A. Brean</u> Address <u>13120 Beaver Terrace Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>4201</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Old age</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>							
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> <u>1964</u> to <u>Oct</u> <u>1966</u> that (I) (we) last saw the deceased alive on <u>Oct 8</u> <u>1966</u> and that death occurred at <u>12 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard P. Delaney</u> 22b. DATE SIGNED <u>Oct 8, 1966</u> 22c. PHYSICIAN'S NAME (Type) <u>Richard P. Delaney</u> 22d. ADDRESS <u>4323 Harvard Street, Silver Spring, Md.</u>				22e. SIGNATURE <u>Charles Judge</u> 22f. DATE SIGNED <u>OCT 13 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Trans-burial</u>		23b. DATE THEREOF <u>Oct 11, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>			
23d. LOCATION (City, town or county) <u>Harrisburg, Pennsylvania</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Glen Carter</u> 24a. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> <u>Warner E. Pumphrey, Inc.</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11430

THIRD DAY OF MARCH

1943

THE UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.
OFFICE OF THE CHIEF OF BUREAU
PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

TO THE CHIEF OF BUREAU
PLANT INDUSTRY
WASHINGTON, D. C.
FROM THE CHIEF OF BUREAU
PLANT INDUSTRY
WASHINGTON, D. C.
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report.]

CERTIFICATE OF DEATH

14437

14437

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY		c. LENGTH OF STAY IN 1b 4 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL		d. STREET ADDRESS 13503 KEATING ST.	
3. NAME OF DECEASED (Type or print) RALPH CLIFTON PHILLIPS		4. DATE OF DEATH Month 10- Day 20 Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-94
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 15 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER, RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Bldg. Construction	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD PHILLIPS		14. MOTHER'S MAIDEN NAME ADA SOUDER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-8646	
17. INFORMANT Mrs. Miriam A. Phillips Address 13503 Keating St. Rockville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute DUE TO (b) 4201 DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH 7 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/14, 1966 , to 10/20, 1966 , that (I) (we) last saw the deceased alive on 10/20, 1966 , and that death occurred at 10:08 PM , from causes and on the date stated above.			
22a. SIGNATURE A. D. Bonifant		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) A. D. BONIFANT, M. D.		22d. ADDRESS Sandy Springs, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 24, 1966	23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery	23d. LOCATION (City or Town) (County) (State) Prince Georges Co., Md.
24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR 8434 Georgia Ave. Silver Spring, Md. DATE OCT 25 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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NAME		DATE	
LAST, FIRST, MIDDLE		MONTH, DAY, YEAR	
SEX		RACE	
AGE		EDUCATION	
OCCUPATION		MILITARY SERVICE	
RESIDENCE		CITY, STATE, ZIP	
BIRTHPLACE		COUNTRY OF BIRTH	
MARRIAGE		SPOUSE NAME	
CHILDREN		CHILD NAME, DATE OF BIRTH	
MILITARY SERVICE		BRANCH, GRADE, DATES	
REMARKS		REMARKS	

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14438

CERTIFICATE OF DEATH

14438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Henry W. Jaeger, Notified & signed release 10/10/66

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY MONTG.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TAKOMA PARK		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON SANITARIUM + HOSP.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GUSSIE ANITA PIPER		4. DATE OF DEATH 10 - 10 - 1966	
5. SEX Fe	6. COLOR OR RACE Wh.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-13-86
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (County & State, or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME VON POPER		14. MOTHER'S MAIDEN NAME LENA KELLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -	
17. INFORMANT -		Address -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) Fracture, pathological, left femoral shaft			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized carcinomatosis from breast			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Pt fell at home	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Silver Spring Md.	
21. I certify that (I) (this hospital) attended the deceased from 9-29 , 19 66 to 10-10 , 19 66 , that (I) (we) last saw the deceased alive on 10-10 , 19 66 , and that death occurred at 5:15 P, from causes and on the date stated above.			
22a. SIGNATURE Henry W. Jaeger MD		22b. DATE SIGNED 10-11-66	
22c. PHYSICIAN'S NAME (Type) Henry W. Jaeger		22d. ADDRESS 1015 Spring St, Silver Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 13, 1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or town) (County) (State) Arlington Virginia	
24. FUNERAL DIRECTOR Arthur Walters, 227 Canan NW. 40 C		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 13 1966	

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STATE OF TEXAS

1928

THE STATE OF TEXAS, COUNTY OF DALLAS, ss. I, the undersigned, Clerk of the County, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, State of Texas, this 1st day of January, 1928.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (Rural)		c. LENGTH OF STAY IN lb 4 yr	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Medical School, NMMC, Bethesda, Md. Building #144		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Bruce Last PITZER		4. DATE OF DEATH Month October Day 29 Year 19 66	
5. SEX Male	6. COLOR OR RACE Cauc.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 April 1917
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Gerrardstown, W. Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harry M. Pitzer, Sr. (DECEASED)		14. MOTHER'S MAIDEN NAME Margaret M. Buchanan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 579-18-5871	
17. INFORMANT (Wife) Mrs. Joyce H. Pitzer		Address 603 Boston Avenue Takoma Park, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun Shot - Wound to Back Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot - self in head with 38 cal. pistol	
20c. TIME OF INJURY Month, Day, Year 4:10 p.m. 10 29 1966	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE John B. Ball		22. DATE SIGNED 10/30/66	
EXAMINER'S NAME (Type) JOHN B. BALL		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/3/1966	
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR W.W. Chambers Funeral Home		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE NOV 2 1966	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14440

CERTIFICATE OF DEATH

14440

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital		d. STREET ADDRESS 7 Sextant Green, S.W.	
3. NAME OF DECEASED (Type or print) Baby Boy POWELL		4. DATE OF DEATH 10-23-1966	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23, 1966
9. AGE (In years last birthday) yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N/A		10b. KIND OF BUSINESS OR INDUSTRY N/A	
11. BIRTHPLACE (County & State, or foreign country) Montgomery, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Powell		14. MOTHER'S MAIDEN NAME Lillian Cromwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) N/A		16. SOCIAL SECURITY NO. N/A	
17. INFORMANT Washington Address D.C.		Mr. John J. Powell, 7 Sextant Green, S.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity, Massive pulmonary atelectasis DUE TO (b) 7625 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that (x) (this hospital) attended the deceased from Oct. 23, 1966 , to Oct. 23, 1966 that (x) (we) last saw the deceased alive on Oct. 23, 1966 , and that death occurred at 7:10 PM , from causes and on the date stated above.			
22a. SIGNATURE T. E. Kelly		22b. DATE SIGNED 25 October 1966	
22c. PHYSICIAN'S NAME (Type) T. E. Kelly, M. D.		22d. ADDRESS Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/26/66	23c. NAME OF CEMETERY OR CREMATORY Arlington National	23d. LOCATION (City or Town) (County) (State) Arlington, Virginia
24. FUNERAL DIRECTOR W. W. Chambers Co. ADDRESS 1400 Chapin Street, N.W., Washington, D.C.		25a. REC'D BY REGISTRAR OCT 26 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

14441

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14441

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>7 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. SAN. & HOSP.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> d. STREET ADDRESS <u>801 Sligo Creek Pkwy</u> e. IS RESIDENCE ON A FARM? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) <u>HELEN JEAN PRAY</u>		4. DATE OF DEATH <u>OCT. 9 1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-43</u>
9. AGE (In years last birthday) <u>23</u>		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Ross</u>		14. MOTHER'S MAIDEN NAME <u>Mary Boyd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mary Boyd Ross</u>		Address <u>6935 Maple St., N.W. D.C.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X</u> <u>Uremia due to Chronic Renal Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <u>Hypertensive cardiovascular disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>		22. DATE SIGNED <u>Oct. 10, 1966</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>10-14-66</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyman Va.</u>	
24. FUNERAL DIRECTOR <u>Thomas Jenkins</u>		25. REC'D BY REGISTRAR <u>Charles Judge</u>	
Address <u>4804 Gaule NW</u>		DATE <u>OCT 17 1966</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14442

14442

1. PLACE OF DEATH a. COUNTY MONTGOMERY County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENSINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WHEATON, Md.	
c. LENGTH OF STAY IN 1b 2 months - 13 days		d. STREET ADDRESS 12716 Epping Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) KENSINGTON GARDENS SANITARIUM		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Richard PREECE SR.		4. DATE OF DEATH Oct. 7, 1966	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1897
9. AGE (In years lost birthday) yrs. 69		10. CITIZEN OF WHAT COUNTRY U. S. A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED Inspector		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.	
11. BIRTHPLACE (County & State, or foreign country) ENGLAND		12. CITIZEN OF WHAT COUNTRY U. S. A	
13. FATHER'S NAME Elam PREECE		14. MOTHER'S MAIDEN NAME ERMA L. ROBERTS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 288-20-1886	
17. INFORMANT William R. PREECE JR.		Address 12716 Epping Terrace Wheaton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerotic cerebral vessels DUE TO dissect (b) dissect DUE TO generalized arterio sclerosis (c) generalized arterio sclerosis		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1966 , to 10/7, 1966 , that (I) (we) last saw the deceased alive on 10/7, 1966 , and that death occurred at LA M , from causes and on the date stated above.			
22a. SIGNATURE [Signature]		22b. DATE SIGNED 10/7/66	
22c. PHYSICIAN'S NAME (Type) H F Kreuzburg		22d. ADDRESS 7652 16th Ave NW Wash DC	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF October 9, 1966	23c. NAME OF CEMETERY OR CREMATORY Union Cemetery	23d. LOCATION (City or Town) (County) (State) Niles, Ohio
24. FUNERAL DIRECTOR John B. Thomas Warrner E. Humphrey, Inc.		25a. REC'D BY REGISTRAR Charles Judge DATE OCT 10 1966	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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U.S. DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
14443 CERTIFICATE OF DEATH 14443

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D. of C.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Keensville</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Keensville Gardens Nursing</u>				e. STREET ADDRESS <u>1809 - 20th Street, N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>THEODORA C. PRESTON</u>				4. DATE OF DEATH <u>October 11 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 27 1881</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Preston</u>				14. MOTHER'S MAIDEN NAME <u>Arlie McFarber</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-09-7309</u>		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral vascular disease</u> 334X DUE TO (b) <u>disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1964</u> to <u>Oct 4, 1966</u> , that (II) (we) last saw the deceased alive on <u>Oct 4, 1966</u> , and that death occurred at <u>1:27 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED <u>10/11/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>H F Kreuzburg</u>				22d. ADDRESS <u>2852 16th St NW Wash DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Oct. 12 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County Md.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20001</u>				DATE <u>OCT 13 1966</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

14444

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 25 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) FAIRLAND NRSg HOME 2101 FAIRLAND RD				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE D.C. b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASHINGTON d. STREET ADDRESS 45 W St., N. W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WALTER J. PROCTER, Sr. First Middle Last				4. DATE OF DEATH October 27 1966 Month Day Year			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH DEC. 28 1973 9. AGE (in years last birthday) 92 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AWNING BUSINESS Manufacturing				10b. KIND OF BUSINESS OR INDUSTRY Manufacturing		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON D.C.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME WALTER PROCTER			
14. MOTHER'S MAIDEN NAME Mary McKay				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No None			
16. SOCIAL SECURITY NO. 579-66-7500				17. INFORMANT Walter J. Procter, Jr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pleural Effusion Cause unknown 0031 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Failure (c) Prostate Resection 2 wks ago. Cystitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				INTERVAL BETWEEN ONSET AND DEATH 3 wks. 3 days.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 1 , 19 66 , to 27 Oct , 19 66 , that (I) (we) last saw the deceased alive on Oct 25 , 19 66 , and that death occurred at 1:30 M, from the causes and on the date stated above.							
22a. SIGNATURE J. B. Queen				22b. DATE SIGNED 10/27/66		22c. PHYSICIAN'S NAME (Type) J. B. QUEEN	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 29, 1966		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION (City, town or county) (State) Rockville, Maryland	
24. FUNERAL DIRECTOR Clark E. Wisor Warner E. Pumphrey, Inc.				25a. REC'D BY REGISTRAR Charles Judge			
25b. REGISTRAR'S SIGNATURE Charles Judge				25c. ADDRESS 8434 Georgia Ave. Silver Spring, Md.			
25d. DATE OCT 31 1966							

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